Committee Findings
and Recommendations

Appendices for
DCF Monitoring and Evaluation

Approved December 20, 2007

Legislative Program Review
& Investigations Committee

Connecticut General Assembly

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APPENDIX A
Child Welfare Quality Assurance Framework Components

Goal	Steps	Actions
Drive practice to achieve desired outcomes	Step 1: Adopt outcomes and standards	<u>Define outcomes</u> • Make goals an explicit part of the statewide strategic plan • Use as basis for setting client level outcomes and service quality standards to meet the needs of children and families <u>Define practice standards</u> • Ensure outcomes and standards are communicated throughout the organization • Develop standards that define the expectations of day-to-day practice
Create a culture that supports quality improvement	Step 2: Incorporate Quality Improvement throughout the agency	• Incorporate main outcomes and indicators in agency strategic plan • Create a Quality Improvement structure that monitors performance and supports quality • Involve wide range of staff and organizations in these initiatives; engage external stakeholders • Communicate quality expectations throughout the agency and broader community • Include them in budgets, training and personnel performance evaluations, licensing standards, provider contracts
Use data and information to inform the quality improvement process	Step 3: Gather data and information	• Collect and continually track quantitative data on outcomes and systemic factors • Conduct case reviews (both record reviews and qualitative case reviews) • Gather input from children and families and external stakeholders • Use all available information such as internal and external evaluations of programs; evaluations of staff/provider training sessions; legislative audits; reports from citizen review panels; child fatality review team results
Translate results into understandable, relevant information	Step 4: Analyze data and information	<u>Involve a variety of staff in analyzing information</u> • Dedicated Quality Improvement staff, administrators, managers, and staff at all levels, external stakeholder and community members, consultants, university staff) <u>Translate data and information into quality assurance reports</u> • Useful types are: outcome reports; practice reports; compliance reports • Useful formats are comparative, exception, and early warning • On a systemwide level, have a regular process for analyzing quality data <u>Communicate regular information to all employees about service quality</u>
Plan and implement improvements that will enhance service quality and outcomes for children and families	Step 5: Use analysis and information to make improvements	• Create feedback loops; • Feed results of process and analyses back to staff in variety of ways: • Evaluate actions taken; continually check effectiveness and make decisions about revisions

Source: *A Framework for Quality Assurance in Child Welfare*, National Child Welfare Resource Center for Organizational Improvement, Edmund S. Muskie School of Public Service, March 2002.

<table>
<tr><th colspan="3">APPENDIX B. SUMMARY OF DCF MAJOR GOALS</th></tr>
<tr><td>AGENCYWIDE GOALS</td><td colspan="2"><u>State Statute</u>
• Protect children from abuse or neglect; strengthen families and make homes safe, provide a temporary or permanent nurturing and safe environment for children when necessary
• Prepare and maintain a written plan for care, treatment and permanent placement of every child and youth under department supervision
• Provide a comprehensive, integrated statewide system of services including prevention for children and families at risk because of abuse, neglect, delinquency, and behavioral health problems

<u>Agency Policy</u>
• Mission: To protect children, improve child and family well-being and support and preserve families. These efforts are accomplished by respecting and working with individual cultures and communities in Connecticut, and in partnership with others.
• Overarching Principle: Safety, Permanency, Well-Being
• Guiding Principles (5): Families as Allies; Cultural Competence; Partnerships; Organizational Commitment; Work Force Development
• Goals: Positive Outcomes for Children (22 outcomes, which are also the exit plan compliance measures for Juan F. consent decree; see attached)</td></tr>
<tr><td rowspan="2">MANDATE & MAJOR PROGRAMS GOALS</td><td>MANDATE</td><td>MAJOR PROGRAMS</td></tr>
<tr><td>Child Protective Services</td><td>• State Statute -- see agencywide, above
• External Requirements:
  • 7 Federal CFSR Outcomes (attached) regarding safety, permanence and well-being
  • 22 Juan F. Exit Plan Outcome Measures (attached) regarding safety, permanence and well-being
• Agency policy: protect children, strengthen families so children can stay at home, help substitute caregivers provide temporary care, find permanent homes through reunification, adoption, guardianship or independent living (agency budget)</td><td>• <u>Hotline</u> (DCF centralized child abuse and neglect reporting)
  - provide professional, timely response to reports of alleged child abuse/neglect and services to ensure the best protection of children
• <u>DCF Area Offices social work services</u>
  - help ensure children are safe, families are supported, children placed out of home are reunified with their biological families or placed in permanent homes
• <u>Community-based contracted services</u> (e.g., in-home family preservation programs, parent aides)
  - strengthen families so children can remain safely at home
• <u>Foster Care</u>
  - provide for a child's needs in a substitute family experience until return home is possible, or, if not, until an alternate permanent home can be found</td></tr>
</table>

			• Adoption - *provide a permanent home for children who cannot return to their biological families* • Adolescent Services - *assist older youth to have permanent relationships with caring adults and be prepared for self-sufficient, productive adult life*
	Children's Behavioral Health	• State statute -- *see agencywide*, above, plus for KidCare/CT BHP: o *develop and implement (with DSS) an integrated behavioral health service system that increases access to quality services by expanding individualized, family-centered, community-based services; maximizing federal revenues; reducing unnecessary residential services; increasing community-based services with savings from reduced residential services; improving administrative oversight and efficiencies; and monitoring individual outcomes and provider and overall program performance.* • Agency policy: *Address children's behavioral health needs, serve children in homes and communities to greatest extent possible, and use the most effective, evidence-based practices* (agency budget)	• KidCare (CT Behavioral Health Partnership) - *enhance and develop comprehensive, coordinated, community-based services to ensure children have access to appropriate services and receive them in the least restrictive environment possible; avoid unnecessary out-of-home residential care* • Contracted community-based contracted mental health and substance abuse services (e.g., emergency mobile psychiatric service, outpatient/child guidance clinic, intensive in-home services, extended day treatment) - *prevent or reduce deterioration in functioning that may require more intensive or restrictive care and promote behavioral health and well-being of children and their families* • Contracted residential mental health and substance abuse services (e.g., residential treatment centers, therapeutic group homes*)* - *treat children whose behavioral health needs are too acute to address in the community; provide structured, out-of-home treatment* • DCF-operated behavioral health residential facilities: Riverview Hospital - *provide comprehensive, family-centered treatment of children and youth with serious mental illness and related behavioral and emotional problems who cannot be safely assessed or treated in a less restrictive setting* High Meadows - *provide emergency diagnostic and residential treatment services* Connecticut Children's Place - *provide comprehensive diagnostic, evaluation and brief treatment for abused and neglected children who require evaluation for an alternative placement and/or are pending another placement*

	Juvenile Services	• State statute -- *see agencywide*, above, plus the following the state juvenile justice system goals: o *hold juveniles accountable* o *provide secure, therapeutic confinement* o *adequately protect community and juveniles* o *provide community-based programs* o *retain and support in home whenever possible* o *individualized treatment planning* o *family inclusion in case management* o *provide supervision, coordination and monitoring to discourage reoffending* o *provide follow up services* o *promote development of community based mental health and other services designed to minimize involvement in the system* o *create and maintain gender-specific programs for juvenile offenders* • Agency policy: *serve children in the juvenile justice system and their families; protect public safety; collaborate with the courts, communities, and partners; and provide a continuum of effective prevention, treatment and transitional services children need to succeeding their families and communities* (agency webpage)	• Out-of-home placement for adjudicated delinquents at DCF-operated secure juvenile correction facility (CJTS) - *promote successful reentry into community of most challenging boys in the juvenile justice system through a full array of innovative vocational, academic, treatment, and rehabilitative services* Contracted residential treatment facilities - *provide out-of-home treatment to youth in the juvenile justice systems who cannot be treated in the community because of acute behavioral health needs and/or legal or family issues* • Parole, Aftercare (community-based services) - *help youth successfully integrate back into their communities through supervision*
	Prevention	• State statute -- under the general agencywide mandate, "… provide comprehensive services including preventive services…"	• Various primary prevention services/initiatives (e.g., suicide prevention, mentoring) funded or directly operated by DCF - *to apply evidence-based or best practice prevention approaches to ensure successful transition from DCF*

		• Agency policy: *enable children and their families to thrive independently in their communities in accordance with seven guiding principles: building on strengths; respecting children, families and communities as partners; supporting comprehensive, collaborative, community-based strategies; respecting cultural and personal identities; promoting innovative, proactive, measurable strategies; ensuing inclusive, accessible, affordable services* (agency webpage and budget)	*involvement or to prevent DCF involvement at all by children and their families* • DCF-operated Wilderness School - *foster positive youth development*

NATIONAL OUTCOMES (CFSR) FOR STATE CHILD WELFARE SYSTEMS	NATIONAL CFSR STANDARDS	DCF POSITIVE OUTCOMES FOR CHILDREN/*JUAN F.* EXIT PLAN OUTCOME MEASURES (EPOMS)
Safety		1. Timely commencement of investigation 2. Timely completion of investigation 3. Appropriate treatment plans 4. Conduct search for relatives 5. Minimize repeat maltreatment 6. Minimize maltreatment in out of home care 7. Timely reunification with parents/guardians 8. Timely adoption 9. Timely transfer of guardianship 10. Place siblings together 11. Minimize re-entry into DCF custody 12. Minimize multiple placements (placement stability) 13. Train foster parents 14. Operate foster homes within licensed capacity 15. Meet service needs of children and families 16. Visit all children quarterly and children in out of home care at least monthly 17. Visit children from in-home cases at least twice a month 18. DCF social worker caseloads not exceed standards 19. Minimize the number of children in out of home residential placements 20. Children in care reaching adulthood achieve educational and vocational goals prior to discharge 21. Discharge plans for children in care reaching adulthood who require adult services submitted to appropriate adult agencies 22. All children entering DCF custody have a multidisciplinary examination (MDE)
1. Children are protected from abuse and neglect	▪ Minimize repeat maltreatment (EPOM 5) ▪ Minimize maltreatment in out of home care (EPOM 6)	
2. Children are safely maintained in their homes whenever possible		
Permanency		
3. Children have permanency and stability in their living situations	▪ Timely reunification (EPOM 7) ▪ Timely adoption/progress toward adoption (EPOM 8) ▪ Permanency for children in foster care (EPOM 7,8,9) ▪ Placement stability (EPOM 12)	
4. The continuity of family relationships is preserved for children		
Well-Being		
5. Families have enhanced capacity to provided for their children's own needs	▪ No national standards at this time	
6. Children receive appropriate services to meet their educational needs		
7. Children receive adequate services to meet their physical and mental health needs		

Appendix C
Contracted Monitoring and Evaluation

The Department of Children and Families periodically uses outside organizations to supplement its internal evaluation resources and to obtain special expertise that cannot be found within the agency. Contracting out for evaluation services also can lend credibility to the results by providing an independent assessment of a program's strengths and weaknesses.

Some of the outside evaluations commissioned by DCF have been required as a condition of federal funding or as part of the agreement for using a proprietary service model. Independent reviews of agency programs also have been directed by the legislature. For example, an outside evaluation of the agency's implementation of the KidCare program, which was carried out by the Child Health and Development Institute of Connecticut (CHDI), was a statutory mandate.

In addition to program-specific evaluation projects, the department also contracts for a variety of on-going monitoring and evaluation services. These services range from conducting child fatality reviews to managing parts of the agency's child welfare data. With the Department of Social Services, DCF also has contract with a private firm (Value Options) to serve as the Administrative Service Organization for the state's Behavioral Health Partnership. Monitoring and reporting on utilization of, and need, for mental health and substance abuse services by children and families are among the duties of the ASO.

Both types of contracted monitoring and evaluation services are described in more detail below. Information on project-specific contracts for the past five years was developed by the department at the request of the program review committee staff. Efforts by some of the commissioner's staff to start tracking contracted studies began around FY 03. However, as there is no central control over the products resulting from outside monitoring and evaluation efforts, the list provided for this study is not considered comprehensive.

Through interviews with agency managers, advisory groups, and private providers, program review committee staff became aware of several external reviews of DCF programs that were not included on the department's list of contracted evaluations. In addition, some monitoring and evaluation efforts may be carried out as part of other, broader contracts that bureau chiefs, facility heads or other agency managers develop for the programs they administer.

One example is the foster care bureau's contract with the Connecticut Association of Foster and Adoptive Parents for foster parent training and support services. That contract includes a provision for CAFAP to carry out exit interviews with caregivers leaving the system to obtain their feedback about the agency's administration of the program. The foster care bureau also has an agreement with the University of Connecticut to conduct opinion surveys of the general public and providers regarding strengths and weaknesses of state foster care.

At this time, decisions about contracted evaluations are not coordinated throughout the agency and there are no standard criteria for determining when outside services are needed. Like all agency contracted services, however, authorization of an external evaluation or monitoring project is subject to the approval of top management and procurement is overseen by the central office contract, fiscal, and legal staff.

Recent Contracted Evaluations

Over the past five years, DCF has contracted for at least 15 different evaluation projects. Information about each one is summarized in Table C-1. On average, the department contracted for three to four external evaluations per year during this period. The cost of the evaluations included in the table ranged from $8,000 to over $1 million each, depending on the scope and timeframe of services. Overall, the total value of the external evaluation services provided through these contracts was more than $ 2 million.

The majority of the contracted services were for studies related to behavioral health issues. This is due to two main factors. First, as part of its ongoing KidCare initiative, and through its participation in implementing the Connecticut Behavioral Health Partnership, the department has developed and expanded a number of new community-based mental health and substance abuse programs for children and families. Second, many of the new behavioral health intensive in-home services (e.g., MST, IICAPS) involve evidence-based models, which mandate provisions for outside evaluations of their effectiveness.

Most of the evaluations shown in Table C-1 extend over a period of several years, although a few short-term reviews (about one year) have been conducted. A variety of entities are involved in performing evaluations for the department including: non profit providers, such as Village for Families and Children; academic institutions and research centers, like Yale University and the Connecticut Center for Effective Practice (CCEP) of the Connecticut Health and Development Institute; and national consultants and research organizations like Matrix and the Casey Foundation.

Table C-1. DCF Contracted Evaluation Services: FY 03 - FY 07

Project	Organization	Start Date	End Date	Amount
Community KidCare Multi-Year Evaluation and Training	Connecticut Center for Effective Practice / Child Health Development Institute of CT	03/01/05	02/28/09	$1,127,000
MultiSystemic Therapy (MST) - Consultation and Evaluation	Advanced Behavioral Health, Inc	05/01/07	06/30/09	$166,780
Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS) - Consultation and Evaluation	Yale University	01/01/06	06/30/08	$125,000
Develop Evaluation Design Methodology for Differential Response System (DRS)	OMG Center for Collaborative Learning	7/1/2003	9/30/2004	$75,000
Evaluation Adoption Services	Casey Family Services	09/15/02	08/01/03	$50,000
Multi-Dimensional Family Therapy (MDT) Evaluation	Village for Families & Children	01/01/06	12/31/07	$30,000
Evaluation of Positive Youth Development Initiatives (PYDI)	Matrix Public Health Consultants	10/01/05	06/30/08	$220,000
Establish evaluation system for Early Childhood Consultation Partnership - ECCP	Yale University	07/01/07	06/30/10	$420,000

Assessment of implementation of Trauma-informed treatment at Girls Residential Program	CORE Associates LLC	11/20/06	09/15/07	$8,000
Evaluation of the CT Behavioral Health Partnership	Connecticut Center for Effective Practice / Child Health Development Institute of CT	03/01/07	06/30/07	$15,000
Evaluation of Flex Funds/ Non DCF Children	Village for Families and Children	10/15/02	08/30/04	$30,000
Evaluate Mentoring & Other Adolescent Services	Kraimer-Rickaby, Lisa M.A.	04/15/03	12/31/03	$29,722.
Evaluation of Community Collaboratives (training and workforce dev.)	Mika Research and Training	07/01/03	02/28/04	$15,000
Behavioral Health Services Administrative Review (training/tech. asst.)	Fr. Flanagans Boys Town Inc	07/01/07	04/30/08	$32,262
Behavioral Health Services Administrative Review: Mt St. John's (training/tech. asst.)	Fr. Flanagans Boys Town Inc	10/01/06	06/30/07	$31,094
Source of Data: DCF				

In three cases, a report was not produced as part of the contract. Instead, training and other workforce development or technical assistance was provided to department staff as a result of the evaluation. Also, copies of reports regarding two other evaluations (regarding flex funds and mentoring) could not be provided by the department. At the time of the committee's study, several evaluations were still in progress or had just released final reports.

The department's arrangement with the Child Health and Development Institute and its affiliated research entity, the Connecticut Center for Effective Practice (CCEP), differs from the other contacted evaluation services. In many ways, CHDI and the center serve as an independent research resource for the department on children's health and mental health care matters.

Under a competitively awarded, five-year personal service agreement, the institute provides DCF with broadly defined evaluation and training services related to the state's KidCare behavioral health reform initiative. The institute designed the multi-year evaluation to be done in phases, focusing first on implementation and baseline measures, then system capacity and responsiveness issues, and finally on changes in children's outcomes.

From June 2003 through January 2007, CHDI issued six evaluation reports related to KidCare as part of this agreement and two subsequent amendments made to it. These studies examined the Emergency Mobile Psychiatric Services and Care Coordination components of the KidCare system and measured family satisfaction with services received. Currently, the institute is completing a first-year evaluation of the Behavioral Health Partnership, which will include a set of performance indicators to be used as the system "report card." CHDI also has organized and funded on-going training in wraparound service delivery for KidCare local providers and care coordinators.

CHDI. The Children's Health and Development Institute is the operating arm of the Children's Fund of Connecticut, a public charitable foundation established in 1992 to improve

the healthy development of Connecticut's children. CHDI carries out the fund's mission by combining direct funding with research, policy analysis, advocacy and technical assistance that emphasizes family-centered, comprehensive physical and mental health care.

The institute works in partnership with Connecticut hospitals, universities, state agencies including DCF, and other organizations, on a variety of initiatives intended to improve the quality of care for all children in the state. These range from strategic planning for early childhood programs, to training for family-centered, medical home primary care teams to evaluations of the effectiveness of juvenile offender treatment therapies and various DCF KidCare services.

In 2002, the institute created its Connecticut Center for Effective Practice (CCEP), a partnership of two state agencies, DCF and the Court Support Services Division (CSSD) of the Judicial branch, and two higher education institutions, the Psychiatry Department of the University of Connecticut Health Center, and the Yale University Child Study Center. The center's overall mission is focused on developing, training, disseminating, evaluating, and expanding effective practice models for children with serious emotional, behavioral, and addictive disorders. Core funding for CCEP's work comes from the Connecticut Health Foundation. Additional support has been provided from the Children's Fund of Connecticut, the Tow Foundation, and DCF.

One of CCEP's primary activities is working with DCF to identify and implement cost-effective, evidence-based behavioral health treatment services for children and youth. Most recently, the center just completed a study with recommendations for the redesign of children's Emergency Mobile Psychiatric Services as a way of addressing the inappropriate use of hospital emergency departments.

Other Contracted Services

DCF also contracts with outside organizations for ongoing monitoring and evaluation services in several areas. Examples of these types of contracted services are summarized in Table C-2.

Table C-2. Current Ongoing Contracted Monitoring and Evaluation Services

Organization	Service	Contract Period	Contract Value
Chapin Hall	Data sharing agreement/child welfare database (longitudinal data on foster care) and technical assistance with analysis	n/a	$50,000 (One-time set up and service fee)
Univ. of Kansas, School of Social Welfare	Child welfare electronic, web-based management reporting system (ROM)	4/04 - 6/08	$511,827

Center for the Study of Social Policy (CSSP)	*Juan F*. Court Monitor Technical Advisory Committee	11/05 - 12/07	$175,000
Child Welfare League of America (CWLA)	Child fatality reviews; technical assistance and case-specific reports	7/07 - 1/10	$480,000
Value Options, Inc.	Administrative Services Organization for CT Behavioral Health Partnership	8/05 - 12/08	$30,487,811
Source of Data: PRI staff analysis			

Two of the five contracts shown in the table, the Chapin Hall longitudinal foster care data analysis project and the ROM services provided by the University of Kansas, are indirectly related to monitoring and evaluation efforts. They primarily provide DCF with data management services, technical assistance, and advice regarding analysis and performance measurement. Both, however, are critical to the department's ability to assess compliance with *Juan F*. exit plan outcome measures and federal child welfare performance indicators as well as to develop related corrective actions and program improvements plans.

The Center for the Study of Social Policy carries out the Technical Advisory Committee (TAC) function required as part of the *Juan F*. consent decree exit plan. The committee's responsibilities include providing expert advice and technical assistance on methodologies for outcome measures, best practices, and the latest child welfare research. In addition, the TAC occasionally evaluates agency operations. Only one written TAC evaluation report, a 2002 assessment of DCF's quality assurance system, has been issued. Feedback is more often given informally, through memos or meetings. Most recently, the committee arranged for a consultant to help DCF staff develop an agencywide practice model and work on the results-based management system the department calls its Accountability framework.

About three years ago, the Child Welfare League of America, as discussed more fully in the section on outside investigations, was hired to assist the department with its internal child fatality review process. Fatality reviews can be viewed as case-specific evaluations of agency policies and practices. To date, CWLA has conducted over 30 in-depth reviews of deaths and other critical incidents involving children and youth in DCF care.

Value Options was awarded the contract to serve as the ASO for the state's Behavioral Health Partnership in January 2006. Its main roles are administrative and concern authorization and utilization review. However, the ASO also has responsibilities for evaluating the existing behavioral health service network and identifying need for new or expanded programs as well as for assessing the efficiency and effectiveness of clinical work.

APPENDIX D

DCF Federal Grant Funding

Children's Bureau Funded Programs

In addition to the general funding of DCF provided by the U.S. Department of Health and Human Services Children's Bureau, specific grants have been awarded to DCF by the Children's Bureau. These grants have requirements to submit progress and data on a quarterly/annual/periodic basis.

One DCF program funded by a grant from the Children's Bureau under the Adoption Opportunities category is the "Helping to Achieve Permanent Placements for Youth (HAPPY) Program." As with other grants funded by the Children's Bureau, DCF is required to submit progress reports every six months to the Children's Bureau.

SAMHSA Funded Programs

The Substance Abuse and Mental Health Services Administration (SAMHSA), part of the U.S. Department of Health and Human Services, has a mission of building resilience and facilitating recovery for people with, or at risk for, mental or substance use disorders. There are four DCF programs that are funded in part or fully by SAMHSA. They are:

1. Building Blocks for Bright Beginnings (Willimantic)
2. Partnership for Kids Project – PARK (Bridgeport)
3. State Adolescent Substance Abuse Treatment Coordination
4. Hartford Youth Project

There are annual reporting requirements for each of the SAMHSA grants that include plans and accomplishments. Additionally, progress reports and fiscal reports are due every six months. The progress reports require an update on project goals, barriers, and evaluation efforts. SAMHSA site visits occur every two years. A description of the monitoring and evaluation of the Building Blocks for Bright Beginnings grant, now follows.

Building Blocks for Bright Beginnings. The Building Blocks for Bright Beginnings SAMHSA grant is entering its third year of funding and is evaluated by the Yale Consultation Center. Building Blocks was established in cooperation with the Department and the Southeast Mental Health System of Care in partnership with Families United for Children's Mental Health. The purpose of the grant is to enhance the existing coordinated network of mental health and human service providers, community members, and families by providing comprehensive mental health and other services for children, birth through five, with social emotional challenges and their families from Southeast Connecticut, supported by evidence-based practices. Building Blocks is also expected to expand the existing system of care in an effort to increase the capacity and expertise

around early childhood mental health with science-based information on screening, assessment, referral and early intervention.

SAMHSA provides program funding through the Community Mental Health Services Block Grant Program. This funding has the goal of improving mental health services through the support of existing public services and encourages the development of community-based care for individuals with serious mental disorders. The funding supports grassroots initiatives that are creative and cost-effective.

Progress reports and fiscal reports are required every six months, and reapplication for the award occurs every March. Additionally, Building Blocks team members are required to attend two national meetings/conferences per year, and site visits occur every two years.

The most recent SAMHSA site visit (year 2) occurred in November 2006. There were 42 recommendations made by the site visitors including: recruiting and hiring additional clinical staff; creating a flow chart to depict the communication and decision making process within Building Blocks; and keeping clearly documented, detailed records about in-kind matches. DCF grant staff then developed action steps for to each of the recommendations and submitted the report to SAMHSA.

Mental Health Block Grant. Additionally, there is the Mental Health Block Grant from SAMHSA to DMHAS. Approximately $1.3 million of the block grant goes to DCF to supplement respite, FAVOR training, suicide prevention, and maintenance and expansion of the system of care. There are data reporting requirements for the Mental Health Block Grant, including an annual Youth Services Survey for Families (YSS-F). This 10-15 minute telephone survey conducted by the University of Connecticut, Department of Public Policy, is given to caregivers of children who have received services from the behavioral health system. The survey collects information in the following seven areas: cultural sensitivity; access to care; participation in treatment planning; outcomes; functioning; social connectedness; and general satisfaction.

Office of Juvenile Justice and Delinquency Prevention (OJJDP) Funded Programs

There are several DCF programs that are funded by the Office of Juvenile Justice and Delinquency Prevention of the Office of Justice Programs of the U.S. Department of Justice. Funding from the programs comes from the Juvenile Accountability Block Grants (JABG) programs, which is administered by the State Relations and Assistance Division of OJJDP. The goal of the JABG program is to reduce juvenile offending through the use of accountability-based programs that focus on both the offender as well as the juvenile justice system.

Connecticut's JAG grant focuses on programs that have the goal of reducing drug-related and violent crime and also improve the functioning of the criminal justice system.

APPENDIX E

Relationship Between *Juan F.* Consent Decree Goals and Federal Child Welfare Outcome Goals

Table E-1. Relationship Between Juan F Consent Decree Goals and Federal Child Welfare Outcome Goals		
Goal/Outcome	Juan F Outcome Goal	Federal Goal/Standard
Maltreatment recurrence: Of all children who were victims of abuse and/or neglect during the first 6 months of the reporting year, the percent that were victims of another abuse or neglect incident within a 6-month period	#5 – No more than 7%	Performance Measure 1 of CFSR Safety Outcome 1 – No more than 6.1% in round 1; no more than 4.8% in round 2
Maltreatment of children in foster care: Of all children who were in foster care during the reporting year, the percent that were victims of abuse and/or neglect by a foster parent or facility staff member	#6 – No more than 2%	Performance Measure 2 of CFSR Safety Outcome 1 – No more than 0.57% in round 1; no more than 0.33 in round 2
Timeliness of reunification: Of all children who were reunified with their parents/guardians at the time of discharge from foster care, the percent that will be reunified in less than 12 months of their most recent removal from home	#7 – At least 60%	Performance Measure 1 of CFSR Permanency Outcome 1 – At least 76.2% in round 1; part of a composite score in round 2
Re-entry into foster care: Of all children who entered foster care during the reporting period, percent that re-entered foster care in less than 12 months of a prior foster care episode	#11 – No more than 7%	Performance Measure 2 of CFSR Permanency Outcome 1 – No more than 8.6% or less
Timeliness of adoption: Of all children who exited foster care to a finalized adoption, percent that exited foster care in less than 24 months from the time of their most recent removal from home	#8 – At least 32%	Performance Measure 3 of CFSR Permanency Outcome 1 – At least 32%
Placement stability: Of all children who have been in foster care for 12 months/less than 12 months from the time of the latest removal from home, percent with no more than two/three placements	#12 – At least 85% will have no more than 3 placements in a 12 month period	Performance Measure 4 of CFSR Permanency Outcome 1 – At least 86.7% will have no more than 2 placements in a 12 month period

APPENDIX F

Description of Federal Government Monitoring and Evaluation of DCF

During the past three to five years, DCF has been federally monitored by the Children's Bureau of the US Department of Health and Human Services, as well as SAMHSA and JJ. Each of these federal monitoring and evaluation efforts will now be described.

US Department of Health and Human Services Children's Bureau

The U.S. Department of Health and Human Services has a Children's Bureau within its Administration for Children & Families. The Children's Bureau monitors state child welfare services as a way to assist Connecticut and other States in achieving positive outcomes for children and families. Figure F-1 shows the relationships between the reporting systems, reviews, and annual federal reports described in this section.

Children's Bureau Reporting Systems. There are three Federal and State reporting systems administered by the Children's Bureau: 1) Adoption and Foster Care Analysis and Reporting System (AFCARS); 2) National Child Abuse and Neglect Data System (NCANDS); and 3) Statewide Automated Child Welfare Information System (SACWIS). Each will now briefly be described.

1) AFCARS. The Adoption and Foster Care Analysis and Reporting System (AFCARS) is a federally mandated system consisting of one file for foster care cases and one file for adoption cases. AFCARS contains case level information on every child in foster care for whom State child welfare agencies have responsibility for placement, care or supervision (foster care file); and every child who was adopted under the auspices of the State's public child welfare agency (adoption file). AFCARS also contains information about the foster and adoptive parents. Descriptive foster care information from AFCARS, for example, includes:

- number and percent of children entering foster care in the fiscal year who were in care for 7 days or less before being discharged from foster care;
- number and percent of children exiting foster care in the fiscal year who were in foster care for 7 days or less;
- number of children in foster care on the first and last day of the fiscal year and number of children entering and exiting foster care in the fiscal year;
- placement settings for children in foster care;
- case plan goals for children in foster care;
- number of placement settings in the current foster care episode;
- number of foster care episodes of children in foster care at the end of the fiscal year;
- number and percentage of children in foster care for 17 of the most recent 22 months, calculated from the number of all children in foster care on the last day of the fiscal year;

- median length of stay (months) in foster care of children in care on the last day of the year; and
- number of children who discharged to each type of permanency goal and the length of stay in foster care (in months) for those children who discharged to each permanency goal.

The AFCARS data is used to prepare reports such as the Child Welfare Outcomes Report, Child and Family Services Reviews, and Title IV-E Eligibility Reviews. Reporting periods are organized according to Federal fiscal years, with States required to submit data twice a year covering the periods of October 1 through March 31 (report period A), and April 1 through September 30 (report period B). The first AFCARS reporting period occurred more than a decade ago, and covered the October 1994 through March 1995 time period.

As will be described later, some of the information from the foster care file (e.g. current and previous placement history, details about the termination of parental rights) is used in the Child and Family Services Reviews (CFSRs). For example, analytical information from Round 1 of AFCARS included:

- Time to Reunification: For the reporting year, of all children who were reunified with their parents or caretakers at the time of discharge from foster care, the percent that were reunified in less than 12 months from the time of the latest removal from home;
- Time to Adoption: For the reporting year, of all children who exited foster care to a finalized adoption, the percent that exited foster care in less than 24 months from the time of the latest removal from home;
- Placement Stability: For the reporting year, of all children served who have been in foster care less than 12 months from the time of the latest removal from home, the percent that have had no more than two placement settings; and
- Re-entry into foster care: Of all children who entered foster care during the reporting year, the percent that re-entered foster care within 12 months of a prior foster care episode.

2) NCANDS. The National Child Abuse and Neglect Data System (NCANDS) is a voluntary national data collection and analysis system that was developed as a way to meet requirements in the Child Abuse Prevention and Treatment Act (CAPTA) (P.L. 93-247) as amended by the Keeping Children and Families Safe Act of 2003. The 1988 CAPTA directed the Secretary of the Department of Health and Human Services to establish a national data collection and analysis program that would have available State child abuse and neglect reporting information. The information is gathered once a year, with the first report from NCANDS based

on data for 1990, and is based on the Federal Fiscal Year. For FFY 2005, a total of 49 States submitted case-level data to NCANDS. Specifically, CAPTA requires each State to report[1]:

- the number of children who were reported to the State during the year as abused or neglected;
- of the number of children, described in (1), the number with respect to whom such reports were substantiated, unsubstantiated, or determined to be false;
- of the number of children described in (2), the number that did not received services during the year under the State program funded under this section or an equivalent State program, the number that received services during the year under the State program funded under this section or an equivalent state program, and the number that were removed from their families during the year by disposition of the case;
- the number of families that received preventive services from the State during the year;
- the number of deaths in the State during the year resulting from child abuse or neglect;
- of the number of children described in (5), the number of such children who were in foster care;
- the number of child protective services workers responsible for the intake and screening of reports filed in the previous year;
- the agency response time with respect to the provision of services to families and children where an allegation of abuse or neglect has been made;
- the response time with respect to the provision of services to families and children where an allegation of abuse or neglect has been made;
- the number of child protective services workers responsible for intake, assessment, and investigation of child abuse and neglect reports relative to the number of reports investigated in the previous year;
- the number of children reunited with their families or receiving family preservation services that, within five years, result in subsequent substantiated reports of child abuse and neglect, including the death of the child; and
- the number of children for whom individuals were appointed by the court to represent the best interests of such children and the average number of out of court contacts between such individuals and children.

NCANDS data is used for the annual report, Child Maltreatment, which is published each Spring, as well as for CFSRs, in the Child Welfare Outcomes: Annual Report to Congress, and the Program Assessment Rating Tool. NCANDS data, for example, is the basis for two CFSR national data indicators:

- Maltreatment recurrence: Of all children who were victims of abuse and/or neglect during the first 6 months of the reporting year, the percent that were victims of another abuse or neglect incident within a 6-month period
- Maltreatment of children in foster care: Of all children who were in foster care during the reporting year, the percent that were victims of abuse and/or neglect by a foster parent or facility staff member

[1] The most recent reauthorization of CAPTA, The Keeping Children and Families Safe Act of 2003, *Public Law 108-36, (42-U.S.C. 5106), retained these provisions*.

NCANDS data is used in the Program Assessment Rating Tool (PART), which is "a systematic method of assessing the performance of program activities across the Federal government."[2] Children's Bureau programs provided by funds from the CAPTA Basic State Grant use NCANDS data for two measurements for their program assessment rating: improve States' average response time between maltreatment report and investigation; and reduce the percentage of children who are repeat victims of maltreatment within 6 months. Children's Bureau programs provided by funds from the Community-Based Child Abuse Prevention (CBCAP) State Grants use NCANDS data for one measurement for their program assessment rating: decrease the rate of first-time victims per 1,000 children.

There are two parts to the NCANDS data: the Agency file at the aggregated level (referred to as the Summary Data Component (SDC)); and the more detailed case-level data (referred to as the Detailed Case Data Component (DCDC)). Beginning in 2000, the case-level data became the primary source of information, and the aggregated data was almost completely phased out. The aggregated child abuse data cannot be derived from the case-level information contained in the Child File. The agency file at the aggregated level includes:

- screened investigations;
- maltreatment fatalities not reported in the more detailed child level data;
- CPS staffing;
- provision of preventive services; and
- response time to investigation.

The more detailed, case-level data contains the following categories of information:

- demographic characteristics (e.g. age, gender, race);
- details of the alleged maltreatment incident (e.g. report date, maltreatment type, maltreatment disposition);
- description of services received as related to the maltreatment report (including foster care placement); and
- information regarding the alleged perpetrator (e.g. demographic characteristics, relationship to the victim).

Specifically, NCANDS includes the following information:

- *median* time from receipt of an allegation of child maltreatment to the initiation of an investigation;
- *mean* time from receipt of an allegation of child maltreatment to the initiation of an investigation;
- average time to investigation;

[2] *Office of Management and Budget*. Guidance for Completing the Program Assessment Rating Tool (PART). *March 2005*.

- percent of children in foster care who are the subject of a substantiated or indicated maltreatment where the perpetrator is a parent;
- number of reports alleging maltreatment of children that reached a disposition within the reporting year; the total numbers of reports, and the number of unique children associated with reports alleging maltreatment;
- numbers and percentages of reports that were given a disposition of "Substantiated and Indicated", "Unsubstantiated", and "Other";
- numbers and percentages of child cases opened for services, which is based on the number of victims during the reporting period under review;
- numbers and percentages of children entering foster care in response to a child abuse/neglect report; and
- number of child fatalities.

3) SACWIS. The Statewide Automated Child Welfare Information System (SACWIS) is an electronic case management tool for adoption and foster care social workers. It is any of a variety of automated systems designed to process child protective services and child welfare information on a statewide basis. As a federally supported project, the primary goals of SACWIS are: 1) facilitating more efficient child welfare program administration and case management; 2) integrating and coordinating other Federal programs such as Title IV-A, Title IV-D, Title XIX, and NCANDS; and 3) facilitating the collection and reporting of AFCARS data. Although information in SACWIS is used to produce AFCARS reports, not all States have a fully operational SACWIS. Federal funding may be available to develop a SACWIS, and those States with SACWIS are required to use the system to collect the data required by AFCARS. All but seven States are participating in SACWIS and approximately 30 are fully operational. Connecticut has an operational system that is not yet SACWIS compliant.

The SACWIS in Connecticut is called LINK. The Department of Children and Families and the State's Information Systems Division (DOIT) have shared responsibility for the system. LINK became operational more than a decade ago, in July 1996. The LINK system replaced the earlier Case Management System (CMS) that had been in use since the early 1980s.

LINK contains several core elements:

- case management, including participant relationships and demographics, contact/collateral demographics and case closure;
- intake, including CPS reports, voluntary services referrals, and investigations;
- legal, including legal actions and court dispositions, and termination of parental rights status;
- placement, including document placements and visitation plans, and bed requests;
- provider management, including arrangement and maintenance of services, training and support for provider families, contracting with providers and provider information, requests and reservations for beds;
- financial management, including processing payments, collections and determination of eligibility;

- reimbursement management, including maintaining budgets and audits;
- common application functions, including internal messaging, office automation, search function, ticklers, and checklists;
- meeting and document management;
- narrative;
- risk assessment;
- education;
- criminal/background checks;
- treatment planning for the family, children in placement, independent living, and adolescent discharge;
- system and policy help functions;
- worker assignments;
- supervisory approvals;
- behavioral health information;
- multi-level appeal process; and
- expungement and archive process.

LINK has four primary functional areas: service management; provider management; financial management; and common application functions. Each will now briefly be described.

Service management. This function gives workers and supervisors the tools to better manage service delivery including CPS reporting, investigations, risk assessment, voluntary services referrals, case maintenance, and case closing. The management of legal actions, placement, case participant information, medical information and adoption are also included within service management.

Provider management. This function has tools to manage service providers, licensing, contract, and foster homes. Support of the licensing and certification processes, and documentation of home providers is included within provider management.

Financial management. This function contains the business aspects of the Department including the processing of payments and voucher requests. The function also supports the "Random Moment Time Study" (RMTS), which documents and gathers costs associated with administering and operating child welfare programs. The information gives the Department information about the amount of effort workers spend on various activities associated with child welfare case maintenance. The RMTS study includes observing employees activities on an individual basis during random time intervals.

Common application functions. These functions are required by more than one of the LINK subsystems and cover areas such as person management, worker assignment, checklists, ticklers, and security. LINK system help, worker assignments and approvals are also contained within the common application functions.

Additionally, LINK enables DCF to produce key management reports, including the number of children in different types of placement at a particular point in time, caseload trends, and performance statistics that are submitted to the *Juan F*. Court Monitor.

The LINK system excludes information from the participants in programs contained in the Bureaus of Behavioral Health and Medicine as well as Juvenile Services. Dually committed children, however, who are involved both with Child Protective Services or Child Welfare Services as well as Behavioral Health and Medicine and/or Juvenile Services, are included in LINK.

The federal government also has two monitoring systems. Each monitoring system will now be described.

1) Child and Family Services Reviews (CFSR). The Child and Family Services Reviews (CFSR) is a result-oriented, comprehensive monitoring system that was first implemented in fiscal year 2001. ACF developed CFSR to fulfill a mandate in the Social Security Amendments of 1994 (see section 1123A of the Social Security Act) for HHS to promulgate regulations for reviews of State child and family services programs that operate under titles IV-B and IV-E of the Social Security Act.

These annual reports to Congress are intended to ensure that State child welfare agency practice conforms to federal child welfare requirements. The reviews are used to determine what is actually happening to children and families within each State child welfare agency, as well as to help states improve the outcomes of the children and families being served. The results help determine whether State child welfare agencies are achieving acceptable outcomes in the areas of safety, permanency, and well-being for children. The Child and Family Services Reviews calculate national standards based on information from AFCARS and NCANDS.

The CFSRs are based on six central principles and concepts:

1. collaborative effort between the State and the Federal government;
2. use of multiple sources to assess State performance;
3. covers outcomes and systemic factors;
4. addresses both strengths and needs;
5. promotes best practice principles; and
6. emphasizes accountability through potential for financial penalties.

2) Title IV-E Foster Care Eligibility Review. Federally, the Foster Care Program was authorized in 1980 under Title IV-E of the Social Security Act, Section 470 et seq (42 U.S.C. 670 et seq), with the intent of assuring proper care for children requiring placement outside their homes, in a foster family home or institution. The Foster Care Program provides funds to States to help them with foster care maintenance for eligible children, administrative costs, training for staff, foster parents, and staff of child care institutions providing foster care services. In SFY 2007, Connecticut received $106 million for reimbursement for foster care and adoption expenses.

A child is eligible for this financial benefit based on a federal requirement that the child was removed from a family that qualified for, or would have qualified for, cash assistance. The Title IV-E Foster Care Eligibility Reviews also determine whether the State had a valid basis for ensuring that appropriate payments were made on behalf of eligible children, homes and institutions, as specified in the Social Security Act (45 CFR §1356.71 and §472).

As with the Child and Family Services Reviews, the Title IV-E Foster Care Eligibility Review team consists of Federal and State representatives. Minimum size samples of 80 cases are randomly drawn from the State's AFCARS data submission. Using the Title IV-E Onsite Review Instrument, the cases are examined for specific federal eligibility requirements, such as:

- a court order confirming the need to remove the child from the home;
- a court order confirming the State agency's reasonable efforts to preserve the family, when it is safe to do so, and to finalize a permanency plan;
- completed criminal background checks on foster and adoptive parents;
- licensed foster care providers;
- an income test to confirm the child's eligibility; and
- State responsibility for placement and care of the child.

Child and Family Services Plan

The Department is required to submit five-year Child Abuse Prevention and Treatment Act (CAPTA) State Plans to the Administration for Children and Families of the U.S. Department of Health and Human Services. The plans are integrated with Connecticut's Child and Family Services Plan and the Independent Living Plan.

In the last two plans, covering 1995-2004, DCF implemented four areas from the nine potential areas through which the child protective services system may be improved as the focus for the CAPTA State Plan:

1. creating and improving the use of multidisciplinary teams and interagency protocols to enhance investigations;
2. developing, strengthening, and supporting child abuse and neglect prevention, treatment, and research programs in the public and private sectors;
3. developing, strengthening and facilitating training opportunities and requirements for individuals overseeing and providing service to children and families through the child protective services system; and
4. developing, implementing or operating information and education programs or training programs designed to improve the provision of services to disabled infants ("children with medically complex conditions") with life threatening conditions for professionals, parents and caretakers.

For the 2005-2009 CAPTA State Plan, DCF chose to focus on three of the four areas, dropping the training opportunities area of focus due to funding limitations.

Annual Progress and Services Report. The Administration for Children and Families requires state child welfare agencies to submit annual progress and services reports (APSRs) for programs and efforts that receive funds from CAPTA, as well as title IV-B, Chafee Foster Care Independence (CFCIP) and Education and Training Voucher (ETV). The APSR preparation includes documentation of progress made since the last APSR, including efforts related to Child and Family Services Reviews Program Improvement Plans.

Examples of programs/activities funded by CAPTA in 2007-2008 include:

- family based recovery program – Waterbury;
- medically fragile foster care program;
- Multidisciplinary Teams in various locations including Child Guidance Clinic of Southern CT, Middletown Police Benevolent Association, and Charlotte Hungerford Hospital of Waterbury;
- Domestic violence initiative;
- Citizen review panel support;
- Prevention activities including Family Day and public awareness/education on Healthy Early Childhood Topics; and
- Statewide training on working with parents with cognitive limitations.

Examples of programs/activities funded by Chafee Foster Care Independent Living Services (for youth in secondary programs) in 2007-2008 include:

- Indian Child Welfare Act coordination of programs with the tribes to ensure benefits and services are made available to the Indian youth in Connecticut;
- Volunteer mentor program;
- Aftercare to support transition to community life; and
- Driver Education.

Examples of programs/activities funded by the Education and Training Voucher (ETV) (for youth in post-secondary programs) in 2007-2008 include:

- Group homes (Preparing Adolescents for Self-Sufficiency (PASS) Group Homes);
- Wilderness School;
- Life Skills Program; and
- Employment and training (workforce development).

The following must be included for each of the programs in the Annual Progress and Services Report:

- specific accomplishments and progress achieved to date;
- steps the state agency will take to expand and strengthen the range of existing services and develop and implement services to improve child outcomes;

- explanation of revisions to existing goals and objectives;
- update of goals and objectives to incorporate areas needing improvement that were identified in a CFSR, title IV-E, AFCARS, or other improvement plan;
- description of services to be provided, highlighting any changes or additions in services or program design and how the services will achieve program purposes; and
- population(s) served.

Other aspects described include collaboration, program support, tribal consultation, monthly caseworker visit data and state plan requirements, and financial and statistical information reporting.

The Annual Progress and Services Report is reviewed by Regional ACF staff, and the Department responds to any clarifying questions. Examples of recent clarifications required of DCF were:

- provide more information on how the Department is reaching out to collaborate with the courts;
- include information regarding the cost allocation of training expenses in the training plan;
- clarification about the information provided on caseworker visits with the child and match with new federal requirements;
- break out the number of new and ongoing Education and Training Vouchers by year; and
- provide the actual amount of FFY 2005 Chaffee funds used to pay for room and board for 18-21 year olds.

SACWIS Assessment Review. The Children's Bureau conducts an assessment of how well the State's SACWIS is functioning approximately one year after it becomes operational. The SACWIS Assessment Review (SAR) includes a one-week, on-site review conducted by the Children's Bureau Division of State Systems. Approximately six weeks prior to the review, states provide the Children's Bureau with background information by completing a SACWIS Assessment Review Guide. The on-site review includes a system walk-through and interviews with users of the system.

Following the SAR site-visit, a detailed exception report is generated, that gives the State a comprehensive description of the review team's findings. Only after the State has either modified the SACWIS or developed an acceptable corrective action plan can the review process be considered finalized.

The first SAR for Connecticut occurred in 1998, and the most recent occurred in September 2006, with the purpose to evaluate progress toward completing SACWIS (the LINK system). As part of the visit, the team assessed areas covered in the Connecticut SACWIS Assessment Review Report (SARR). Specifically, the monitoring visit was intended to:

- assess the progress of Connecticut on addressing issues that remained open in the SACWIS Assessment Review Report (SARR);

- verify continued executive sponsorship, project leadership, and project funding; and
- observe use and efficiency of LINK by interviewing some of the system users.

This review found staff not always aware of the capabilities of LINK, issues related to the system help and user training, and slowness of LINK system response time. The Department is currently developing a way to address some of the issues that continue to impact data quality such as a way to easily allow editing and correction of data entry. Called "PALS," the improvement is scheduled for completion and implementation in Spring 2008.

Additionally, following this site visit, the Administration for Children and Families issued a new SACWIS-related program instruction having the intent of holding Connecticut accountable for completing its SACWIS. Connecticut submitted action plans (to complete SACWIS). Some of the 21 SACWIS issues addressed by the action plans include:

- Alerts on licensing status changes and revocation of foster care licenses;
- Compliance with SACWIS' Title IV-E Eligibility requirements;
- Information documenting activities and outcomes associated with investigations are contained in MS Word documents and need to be integrated into LINK; and
- Collection and recording of special needs/problems requires workers to enter information, some of it duplicate information, onto multiple LINK screens.

The Department is planning to submit a SACWIS update report in August 2007 that will contain a retroactive 2007 plan and a new 2008 plan.

In concert with these three reporting systems, the Children's Bureau monitors outcomes for children and families through:

1. Child and Family Services Reviews (CFSRs);
2. Child Welfare Outcomes Report to Congress; and
3. Title IV-E Foster Care Eligibility Reviews.

Statewide Assessment. The CFSR process occurs in two phases. The first phase is the statewide assessment, during which the State analyzes its child welfare data and practice. It involves external partners or stakeholders and the Children's Bureau Central and Regional Office staff. The efforts of this Statewide Assessment Team are guided by completion of the Statewide Assessment Instrument. Using Connecticut as an example, the Statewide Assessment Instrument has five sections:

1. general information about DCF;
2. data profiles for the four safety and permanency related outcomes;
3. narrative assessment of the seven outcome areas;
4. DCF characteristics and narrative responses for each of the seven factors; and
5. DCF's assessment of its strengths and challenges as well as the identification of issues and geographic locations requiring further examination during the onsite review.

Data to complete the Statewide Assessment Instrument comes from the AFCARS and NCANDS data bases. Note that only safety and permanency outcomes are addressed in the State Data Profiles. There are two safety measures and four permanency composites on the data profiles that are then assessed for conformity with the national standards.

The Statewide Assessment information is used to:

- Guide site selection by the Children's Bureau and the State for the onsite review;
- Provide an overview of the State child welfare agency's organization, capacity, and performance for the Onsite Review Team;
- Facilitate identification of issues that need additional clarification before or during the onsite review;
- Serve as a key source of information for rating the CFSR systemic factors;
- Provide context for the outcome ratings;
- Enable States and their stakeholders to identify early in the CFSR process the areas potentially needing improvement and to begin developing their PIP approach;
- Inform the Child and Family Services Plan and the Annual Progress and Services Report (APSR) processes;
- Educate stakeholders about State strengths and needs and enlist their support in developing and making program improvements;
- Inform stakeholders and the public about the improvements/progress the State has made since the previous Statewide Assessment; and
- Openly share with stakeholders and the public the areas that the State child welfare agency has identified as continuing to need improvement.

On-Site Reviews. Following completion of the Statewide Assessment, as required in statute (45 CFR 1355.33(c)), the Child and Family Services Reviews includes an on-site review, during which Federal and State teams examine outcomes for children and families by assessing child welfare practices, and assessing systemic issues through stakeholder interviews.

The On-Site Review includes: 1) a random review of foster care and in-home case records; 2) interviews with children and families receiving services; and 3) interviews with community stakeholders (e.g. courts, community agencies, foster families, caseworkers, service providers). The purpose of the on-site review is to evaluate progress in achieving the qualitative CFSR outcomes. The site visit lasts for one week.

The on-site review is conducted by a team of Federal and State representatives (including external partners). For Connecticut, this Statewide Assessment Team includes representatives of the sources that DCF consulted with when developing its title IV-B State plan. Court personnel, youth, parents and staff from provider agencies are included on the team. Members may serve as reviewers of case records or assist in the development of a possible subsequent Program Improvement Plan.

CFSR Outcomes. There are seven CFSR outcomes, covering the areas of safety, permanency, and child and family well-being. Two of the seven CFSR outcomes (Safety Outcome #1 and Permanency Outcome #1) are derived from aggregated AFCARS and NCANDS data, and have national standards associated with them. The seven CFSR outcomes are:

1. Children are, first and foremost, protected from abuse and neglect (Safety Outcome 1);
2. Children are safely maintained in their homes whenever possible and appropriate (Safety Outcome 2);
3. Children have permanency and stability in their living situations (Permanency Outcome 1);
4. The continuity of family relationships and connections is preserved for children (Permanency Outcome 2);
5. Families have enhanced capacity to provide for their children's needs (Well-Being Outcome 1);
6. Children receive appropriate services to meet their educational needs (Well-Being Outcome 2); and
7. Children receive adequate services to meet their physical and mental health needs (Well-Being Outcome 3).

In addition to these seven CFSR outcomes, there are seven operational, systemic factors that affect the agency's ability to achieve these seven CFSR outcomes. The seven systemic factors examined for conformity with national standards are:

1. Statewide Information System;
2. Case Review System;
3. Quality Assurance System;
4. Training;
5. Service Array;
6. Agency Responsiveness to the Community; and
7. Foster and Adoptive Parent Licensing, Recruitment, and Retention.

The assessments of States on these seven systemic factors are part of the requirements in the title IV-B and IV-E regulations. States are rated on a scale of 1 to 4 for each systemic factor, with criteria for rating each factor found in the CFSR Procedures Manual. Ratings of "3" or "4" indicate "substantial conformity" and ratings of "1" or "2" indicate "not in substantial conformity" with the factor. The assessment on these seven systemic factors is based on ratings on 22 indicators. The State is rated on each indicator as having either a "strength" or an "area needing improvement." According to the Children's Bureau website, States are rated on:

- the extent to which they have met these seven requirements through systems, policies, procedures, or training;
- how these systems are operating in day-to-day practice in the field, as demonstrated through data or stakeholder input; and
- the effectiveness of the state with regard to the systemic factors in achieving positive outcomes for children and families.

National Standards. The first round or cycle of CFSR reviews of every State, the District of Columbia, and Puerto Rico were conducted between FY 2001 and FY 2004. The national standards for the first round of CFSR were based on relative—rather than absolute--performance across States for each of the six CFSR data measures related to safety and permanency goals. The standard was set at the 75th percentile based on NCANDS and AFCARS data from earlier reporting periods (see CFSR Round One column for national standards).

The second round or cycle is scheduled to occur between FFY 2007 and FFY 2010. The national standards for the second round of CFSRs are higher than the first round, and are based on 2004 State performance levels. Connecticut is scheduled for its second round or cycle of CFSR review in FFY 2008, on September 22-26, 2008.

In general, the Children's Bureau reported[3] that:

- Of the seven outcomes measured by the CFSRs, Well-Being Outcome 2 ("children receive services to meet their educational needs") was met by the highest number of States (16). No States achieved substantial conformity to Well-Being Outcome 1 ("families have enhanced capacity to provide for children's needs") or to Permanency Outcome 1 ("children have permanency and stability in their living situations"); and
- States performed better on systemic factors, with more than half of States showing substantial conformity with each of five of the seven factors: (1) Training, (2) Quality Assurance, (3) Statewide Information Systems, (4) Agency Responsiveness to the Community, and (5) Foster and Adoptive Parent Licensing, Recruitment, and Retention.

2) Child Welfare Outcomes Report to Congress. The U.S. DHHS has developed Annual Reports to Congress in accordance with section 479A of the Social Security Act (as amended by ASFA in 1997). (The USDHHS is behind in producing these reports to congress; as of October 25, 2007, the 2004 report information still had not been published.) These reports provide information about state performance on the seven national child welfare outcomes as well as population characteristics to provide a context for the information. The population characteristics in the Report to Congress include:

- number and race/ethnicity of children in the state's population (from U.S. Census Bureau, Current Population Survey);
- number and characteristics (age, race/ethnicity, and type of maltreatment) of child maltreatment victims;
- number and characteristics of children in foster care at the start of the fiscal year and of children who entered and exited foster care during the fiscal year;
- median length of stay of children in foster care;
- number and characteristics of children "waiting for adoption"; and

[3] Children's Bureau Express, October 2004

- number and characteristics of children for whom an adoption was finalized during the fiscal year.

While both the Report to Congress and CFSR contain information on the national child welfare outcomes, the CFSR is considered more of a monitoring system, providing more comprehensive information about state performance. The Report to Congress, on the other hand, is limited to automated data contained in AFCARS and NCANDS.

Both the Report to Congress and CFSR, however, share similar goals of informing Congress, the USDHHS, the States, and the public about performance in achieving desired outcomes for children in the public child welfare systems, and identifying areas needing improvement. The USDHHS, therefore, connected the Report to Congress and CFSR by establishing national performance standards for six of the measures contained in the Report to Congress:

1. recurrence of maltreatment;
2. incidence of child abuse and/or neglect in foster care;
3. foster care re-entries;
4. stability of foster care placements;
5. length of time to achieve reunification; and
6. length of time to achieve adoption.

These national performance standards have been modified somewhat, and the changes to the CFSR highlight the differences.

Changes to CFSR. Following the first round of CFSR reviews, ACF contracted with a consultant to study the process and make recommendations. One adopted recommendation that came from respondents to the Federal Register notice and others in the field, was to have all data measures address performance from a positive perspective. Another adopted recommendation was to replace the six existing CFSR single data measures (used to set national standards) with four data composites and two single measures. The composite scores were scaled from 50 to 150, with higher scores indicating better performance.

The composite scores combine related measures of permanency already contained on AFCARS, and have the following advantages:

- provide a more effective assessment of State performance as combined, weighted measures are more reliable and valid than the individual measures on which the composite is based;
- provide a more holistic view of State performance in a particular domain than a single data measure can achieve;
- ensure that the data component of a State's performance with regard to a particular domain will not depend on one measure; and
- data composites are being used by the Federal government to assess other programs.

In order to be considered in substantial compliance during CFSR Round One, States were required to substantially achieve the outcome in 90 percent of reviewed cases. For CFSR Round Two, the percent that must substantially achieve the outcome increased to 95 percent.

Table F-1 shows the changes in the two national child welfare standards and outcomes that occurred between round one and round two. Note that the two national standards are based on State performance in FY 2003 and FY 2004.

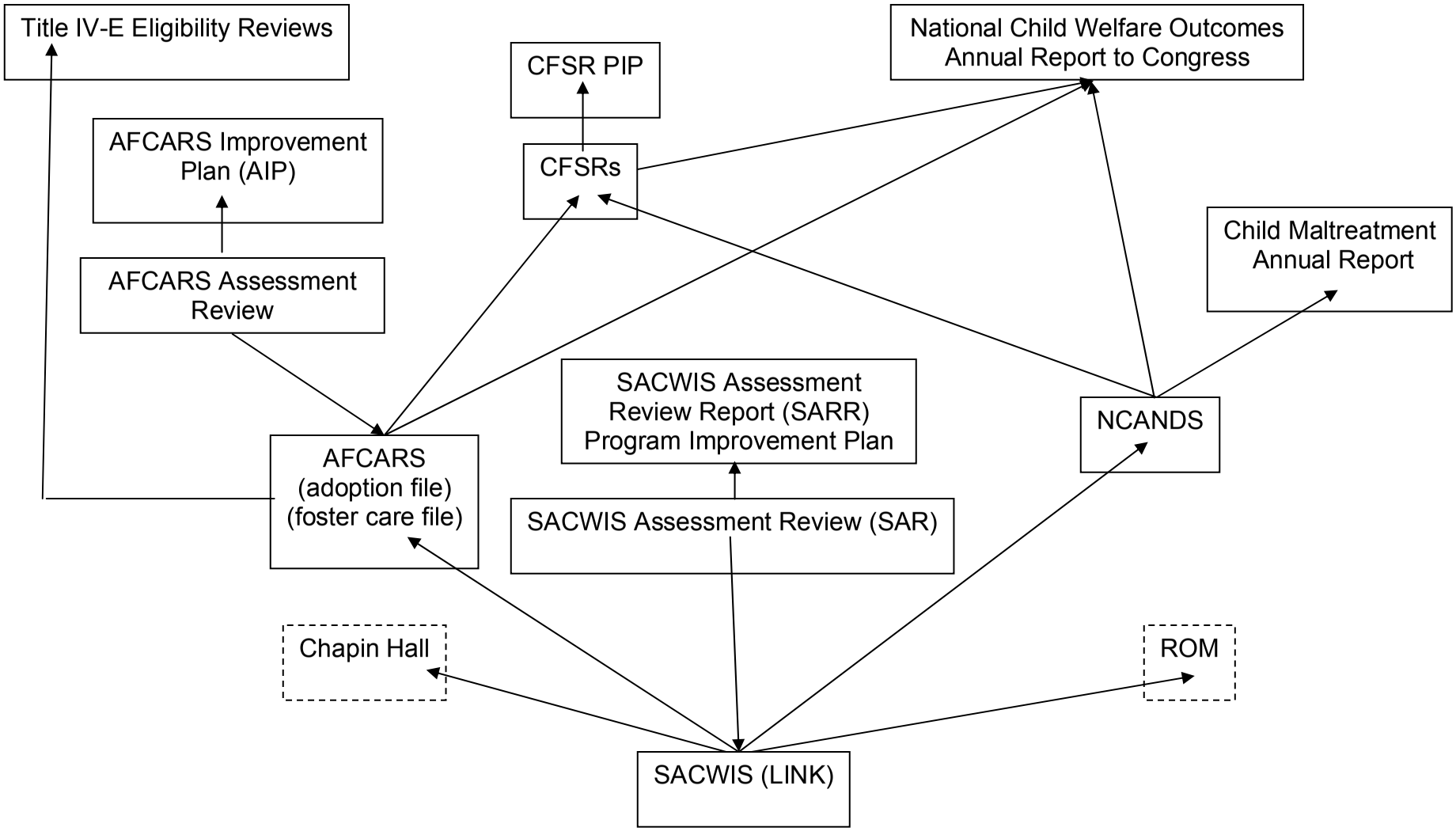
Table F-1. Changes to National Child Welfare Standards and Outcome Measures	
CFSR Round One (**Performance Measure**--*national standard*)	CFSR Round Two
National Child Welfare Outcome: Children are, first and foremost, protected from abuse and neglect (CFSR Safety Outcome 1)	
Performance Measure 1: **Repeat maltreatment**—*Of all children who were victims of substantiated or indicated child abuse and/or neglect during the first 6 months of the reporting period, 6.1 percent or less had another substantiated or indicated report within a 6-month period.* Performance Measure 2: **Maltreatment of children in foster care**—*Of all children who were in foster care during the reporting period, 0.57 percent or less were the subject of substantiated or indicated maltreatment by a foster parent or facility staff member.*	Performance Measure 1: **Recurrence of maltreatment**—*Of all children who were victims of a substantiated or indicated maltreatment allegation during the first 6 months FY 2004, 95.2 percent or more were not victims of another substantiated or indicated maltreatment allegation during a 6-month period.* Performance Measure 2: **Maltreatment of children in foster care**—*Of all children in foster care in FY 2004, 99.67 percent or more were not victims of a substantiated or indicated maltreatment by a foster parent or facility staff members.*
National Child Welfare Outcome: Children have permanency and stability in their living situations (Permanency Outcome 1)	
Performance Measure 1: **Timeliness of reunification**—*Of all children who were reunified with their parents or caretakers at the time of discharge from foster care, 76.2 percent or more were*	(Four Composite Measures) Composite 1: **Timeliness and Permanency of Reunification Composite incorporating two components and four measures** (National Standard for this composite score: 106.7 or higher).

reunified in less than 12 months from the time of the latest removal from home. Performance Measure 2: **Re-entry into foster care**—*Of all children who entered foster care during the reporting period, 8.6 percent or less were re-entering foster care in less than 12 months of a prior foster care episode.* Performance Measure 3: **Timeliness of adoption**—*Of all children who exited foster care to a finalized adoption, 32 percent or more exited foster care in less than 24 months from the time of the latest removal from home.* Performance Measure 4: **Placement stability**—*Of all children who have been in foster care for less than 12 months from the time of the latest removal from home, 86.7 percent or more have had no more than two placement settings.*	<u>Component A:</u> Timeliness of reunification (has 3 measures) 7. *Of all the children discharged from foster care to reunification in FY 2004 who had been in foster care for 8 days or longer, what percent were reunified in less than 12 months from the time of the latest removal from home?* 8. *Of all the children discharged from foster care to reunification in FY 2004 who had been in foster care for 8 days or longer, what was the median length of stay from the time of the most recent entry into foster care until discharge to reunification (in months)?* 9. *Of all children entering foster care for the first time in the first 6 months of FY 2004 who had remained in foster care for 8 days or longer, what percent were discharged from foster care to reunification in less than 12 months of the time of entry into foster care?* <u>Component B</u>: Permanency of reunification (has 1 measure) 1. *Of all children discharged from foster care to reunification in FY 2003, what percent re-entered foster care in less than 12 months?* Composite 2: **Timeliness of Adoptions Composite incorporating three components and five measures** (National Standard for this composite score: 102.1 or higher) <u>Component A:</u> Timeliness of adoptions of children discharged from foster care (has 2 measures) 1. *Of all children who were discharged from foster care to a finalized adoption in FY 2004, what percent was discharged in less than 24 months from the time of the latest removal from the home?* 2. *Of all children who were discharged from foster care to a finalized adoption in FY 2004, what was the median length of stay in foster care (in months) from the time of removal from the home to the time of discharge from foster care?* <u>Component B:</u> Progress Toward Adoption for Children Who Meet ASFA Time-In-Care Requirements (has 2 measures)

	1. Of all children in foster care on the first day of FY 2004 who were in foster care for 17 continuous months or longer, what percent were adopted before the end of the fiscal year? *2. Of all children in foster care on the first day of FY 2004 who were in foster care for 17 continuous months or longer, what percent became legally free for adoption (i.e., a TPR was granted for each living parent) within 6 months of the beginning of the fiscal year?* <u>Component C:</u> Progress Toward Adoption of Children Who Are Legally Free for Adoption (has 1 measure) *1. Of all children who became legally free for adoption during FY 2004, what percent were discharged from foster care to a finalized adoption in less than 12 months?* Composite 3: **Achieving Permanency for Children in Foster Care Composite incorporating two components and three measures** (National Standard for this composite score: 105.2 or higher) <u>Component A:</u> Achieving Permanency for Children in Foster Care for Extended Periods of Time (has 2 measures) *1. Of all children who were discharged from foster care and were legally free for adoption (i.e., there was a TPR for each living parent), what percent exited to a permanent home defined as adoption, guardianship, or reunification prior to their 18th birthday?* *2. Of all children in foster care for 24 months or longer at the start of the fiscal year, what percent were discharged to permanency in less than 12 months and prior to their 18th birthday*? <u>Component B:</u> Children Emancipated Who Were in Foster Care for Extended Periods of Time (has 1 measure) 1. *Of all children who exited foster care with a discharge reason of emancipation or who reached their 18th birthday while in foster care, what percent were in foster care for 3 years or longer?*

	Composite 4: **Placement Stability Composite incorporating three measures** (National Standard for this composite score: 108.2 or higher) *1. Of all children in foster care for 8 days or longer and less than 12 months, what percent had two or fewer placement settings?* *2. Of all children in foster care for at least 12 months but less than 24 months, what percent had two or fewer placement settings?* *3. Of all children in foster care for at least 24 months, what percent had two or fewer placement settings?*
Source: Federal Register: June 7, 2006 (Volume 71, Number 109), pages 32969-32987.	

Figure F-1. Federally Required Reviews, Reports and Automated Systems



Appendix G

Description of Accrediting Body Requirements

Accreditation is intended to put forth standards against which to assure a minimum level of care. It has been reported that accreditation has the benefit of formalizing and clarifying policies and procedures. It is also useful as a credential signifying organizational quality to consumers, funders and other key stakeholders. Accreditation usually requires an organization to submit evidence of adherence to required standards (the "self-study") and undergo a site visit by inspectors of the accrediting body. Areas found to be out of compliance require correction before accreditation or reaccreditation is granted.

The Department of Children and Families currently receives accreditation for Riverview Hospital through the Joint Commission (formerly the Joint Commission on Accreditation of Healthcare Organizations). Additionally, the Connecticut Juvenile Training School is pursuing accreditation by the American Correctional Association. Further, the Connecticut General Assembly passed legislation in 2005 (P.A. 05-246) requiring DCF to apply for accreditation by the Council on Accreditation within a reasonable time. Each of the accrediting bodies will now be described.

The Joint Commission

The Joint Commission, until 2007 the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), currently accredits Riverview Hospital, Connecticut's only state-run psychiatric hospital for children between the ages of 5 and 17. The Joint Commission is a US-based non-profit organization formed in 1951 with a mission "to continuously improve the safety and quality of care provided to the public through the provision of health care accreditation and related services that support performance improvement in health care organizations."[4] They currently accredit approximately 80 percent of all hospitals in the country.

The Joint Commission accreditation steps include preparation of an in-depth self-study followed by a site visit. There are several hundred standards for accreditation that fall into 11 areas:

1. Ethics, rights and responsibilities;
2. Provision of care, treatment and services;
3. Medication management;
4. Surveillance, prevention and control of infection;
5. Improving organizational performance;
6. Leadership;
7. Management of environment of care;
8. Management of human resources;
9. Management of information;
10. Medical staff; and
11. Nursing.

[4] The Joint Commission website: www.jointcommission.org

During the site visit, the performance of the hospital is compared to the relevant standard for that area. Site visits occur at least once every 39 months. Unannounced site visits may occur at any time, as was the case, for example, for Riverview Hospital in October 2004. Unannounced site visits may be prompted by at least one patient care concern received from the public. Note that the Joint Commission does not tell the hospital what the complaint is about; however, their targeted inspections give some indication of the areas of concern.

The Joint Commission now uses a tracer methodology. Upon arrival, Joint Commission site reviewers, or surveyors, request case records to review. Based on the records reviewed, the surveyors will trace a child's stay at Riverview Hospital. Any of the services used during the child's stay may be assessed according to Joint Commission standards. Any internal services used to support the child's stay at the hospital, such as building safety issues, may also be reviewed.

Riverview Hospital was first accredited as a psychiatric hospital following a survey on December 13-15, 2003. Prior to 2003, Riverview Hospital was accredited as a behavioral health facility. The 2003 three-day site visit included a child psychiatrist and psychiatric nurse sent by the Joint Commission. Following the 2003 site visit, one recommendation was identified that required follow up: Orientation, Training, and Education of Staff (Note that there are recommendations that do not require follow up). The site visitors noted that the facility's required annual report failed to fully address staff competencies, patterns and trends and competence maintenance activities. Riverview Hospital had six months to report back on their progress to comply with the recommendation. The improvement areas identified during the 2003 and 2006 Joint Commission site visits are summarized in Table G-1.

Table G-1. Improvement Areas Identified During the 2003 and 2006 Joint Commission Site Visits

Area	2003 Site Visit	2006 Site Visit
Ethics, rights and responsibilities	None	None
Provision of care, treatment and services	None	**Pain is assessed in all patients**
Medication management	None	None
Surveillance, prevention and control of infection	None	None
Improving organizational performance	None	None
Leadership	None	None
Management of environment of care	None	None
Management of human resources	**Orientation, Training, and Education of Staff**	None
Management of information	None	None
Medical staff	None	None
Nursing	None	None

Source: Joint Commission Accreditation Survey Findings: Requirement(s) for Improvement 2003 and 2006.

Riverview Hospital successfully responded to the recommendation by making changes to staffing and the evaluation of staffing effectiveness including overtime, float staff utilization, restraints and seclusions, and patient injuries, the latter falling within the provision of care standards area. Additionally, training was given in the following three areas that had the greatest need: basic computer skills; knowledge of hospital policies and procedures; and supervisory/leadership skills. In September 2004, the Joint Commission notified Riverview Hospital that their response had effectively resolved the required follow up on the orientation, training and education of staff recommendation.

The Riverview Hospital reaccreditation site visit occurred in October 2006. The site review team recommended improvements to elements within the following four areas:

1. data are systematically aggregated and analyzed;
2. medication orders are written clearly and transcribed accurately;
3. medications are dispensed safely; and
4. pain is assessed in all patients.

Note that only the last recommendation area required a response from Riverview Hospital in order to maintain its accreditation. In this instance, the hospital procedures required that pain assessment occur with each patient report of pain and post medication administration. This area was addressed so that now 100 percent of the patient units are using an updated Medication Administration PRN Record, which has been printed to include pain assessment for each pain medication administered.

Riverview Hospital submitted this update to the Joint Commission in April 2007, and was granted reaccreditation dated October 27, 2006. Riverview Hospital will next be undergoing reaccreditation no later than December 2009.

Note that staff from the Office of the Child Advocate shared with the Joint Commission Team what they perceived to be inaccuracies in the review. For example, Riverview Hospital was checked off as having an adequate use of ivs; however, Riverview does not use ivs.

An additional challenge is that Riverview Hospital must adhere to Joint Commission standards, Connecticut statutes, and the federal Centers for Medicare and Medicaid Services (CMS) standards. In the instance of restraints and seclusion, the requirements are slightly different. When there are multiple standards, Riverview Hospital follows the most stringent requirements so that there is not a conflict with any of the standards.

As described earlier, unannounced site visits may occur, and according to the Assistant Superintendent, Riverview Hospital received unannounced site visits on May 17, 2005 and October 11, 2006.

During the May 17, 2005 site visit, the Joint Commission surveyor focused on medication, and patient health and safety issues during construction. As a result of the site visit, Riverview Hospital made the following changes:

- The facility policy and procedures for transfer of patients between levels of care was re-worded to clarify that the receiving psychiatrist would write new medication orders upon transfer of a patient;

- The Riverview Hospital Medical Executive Committee now annually reviews a list of medications that are frequently prescribed and high risk to ensure that medications are dispensed in the most ready-to-administer forms available from the manufacturer or if feasible, in unit-doses that have been repackaged by the pharmacy or licensed repackager; and
- The Riverview Hospital Health and Safety Committee, Safety Director and Facilities Engineer developed an Interim Life Safety Measure Procedure to ensure that the hospital develops and implements activities to protect occupants during periods when a building does not meet the applicable provision of the Life Safety Code (e.g., during construction).

During the October 11, 2006 unannounced site visit, the Joint Commission surveyor focused on medication, the medical credentialing process, time frames for conducting initial assessments, and coordination of care, treatment and services. As a result of the site visit, Riverview Hospital made the following changes:

- The Riverview Hospital Medical Executive Committee established a separate section of the patient chart for medication reconciliation and developed forms for tracking and documenting admission medication for internal transfers from unit to unit and from Riverview Hospital to an outside care provider;
- One missing verification of medical staff licensure was rectified and quarterly audits of all personnel files for compliance established;
- The Riverview Hospital policy of completing the medical history and physical exam within 24 hours of inpatient admission was reviewed with all medical staff and corrected for the two patients where this had not occurred; and
- The Riverview Hospital Medical Records Committee approved revisions to the Treatment Planning form so that hospital dietician recommendations are now included and audited on a monthly basis.

In addition to the hospital accreditation process, in 2005 the Joint Commission began recognizing hospitals for meeting National Patient Safety Goals. The purpose of the goals was to highlight problematic areas in health care and describe evidence- and expert-based solutions to these concerns. The patient safety goals for hospitals in 2006 were:

- improve the accuracy of patient identification;
- improve the effectiveness of communication among caregivers;
- improve the safety of using medications;
- reduce the risk of health care associated infections;
- accurately and completely reconcile medications across the continuum of care; and
- reduce the risk of patient harm resulting from falls.

Additionally, because Riverview Hospital uses a consulting pharmacy rather than an on-site pharmacy, the Joint Commission requires monthly documentation that demonstrates compliance with standards for pharmacy practice.

In 2006, Riverview Hospital was recognized for meeting all of the National Patient Safety Goals. It is an expectation of the Joint Commission that hospitals will meet all national patient safety goals. These goals are posted throughout the hospital and are carried by Riverview Hospital staff with their identification badges.

The cost of accreditation by the Joint Commission includes the direct fee paid annually to the Joint Commission ($2,500) to maintain accreditation, and $5,900 to McLean Hospital (Oryx) for a data comparison required by the Joint Commission. The Oryx submission of data requires five days per month from an Information Systems staff person. There is an additional on-site survey fee of $15,000 on years when the reaccreditation site visit occurs.

The Riverview Hospital Quality Assurance Manger is primarily focused on Joint Commission activities 40 hours per week. This includes Infection Control Coordinator activities, survey readiness activities of the Quality Assurance department, submission of the annual periodic performance review, tri-annual application process, follow-up survey reports and monitoring. In essence, efforts for Joint Commission Accreditation is part of the everyday operation activities of a hospital, largely determining the committees formed, areas monitored, and policies and protocols written.

Council on Accreditation

In 2005, the Connecticut General Assembly passed a bill requiring DCF to become accredited by the Council on Accreditation (P.A. 05-246). The act directed the Commissioner to apply, within a reasonable time, for accreditation of the Department by the Council on Accreditation. A failed bill (SB 334) during the 2007 regular session attempted to amend the statute to require the Commissioner to apply for accreditation no later than October 1, 2007. To date, the Department has not officially sought accreditation from the Council.

The Council on Accreditation is an international, independent, not-for-profit organization that accredits child and family serving agencies and behavioral and healthcare organizations. The Council has been in existence since 1977 when it was co-founded by the Child Welfare League of America and Family Service America (now the Alliance for Children and Families). The standards are based on best practices in the field. The accreditation process requires a self-study (self-evaluation) followed by a site visit. The accreditation is for a four-year period. There are standards for accreditation of the department overall in such areas as:

- continuous quality improvement;
- training and supervision;
- intake, assessment, and service planning;
- financial management; and
- ethical practice, rights, and responsibilities.

Beyond the generic standards, accredited public agencies must also adhere to standards specific to services such as:

- adoption;
- case management;

- extended day treatment;
- family preservation;
- foster care;
- outpatient mental health services;
- residential treatment services; and
- wilderness and adventure-based therapeutic outdoor services.

In addition to private organizations, COA also accredits state administered child welfare agencies like DCF. Currently, Arkansas, Illinois, Kentucky, Louisiana and Maryland are accredited; the COA Public Agency Accreditation Report of June 2007 also identifies six additional state administered child welfare agencies that are currently going through the accreditation process (Maine, Missouri, Ohio, Tennessee, Washington State, and West Virginia).

In preparation for DCF becoming COA-accredited, the Director of Planning, Policy and Program Development, Director of Policy and Accreditation and several other DCF staff attended basic accreditation training in March 2007. The training focused on how to calculate the staffing needed to complete the COA process. The Department has prepared an estimate for DCF and its 14 area offices and facilities to become accredited. Unlike other States with a strong county system where each county may get accredited separately, Connecticut's 14 offices make this function quite spread out, and the accreditation a more involved process. Beyond the area offices, there are also DCF-run facilities that would need to be visited and brought into line with COA accreditation standards. DCF estimates that it will cost as much as $909,675 to become accredited, calculated based on 7-8 part-time positions ($415,000-$475,000) and accreditation fees ($434,675). Funding would then be needed to make improvements required to meet accreditation standards, and additional funding to prepare for subsequent reaccreditation processes.

The Policy and Accreditation Unit of the Planning, Policy and Program Development division of the Bureau of Continuous Quality Improvement is responsible for shepherding through the accreditation. Concern has been expressed that COA standards change frequently and the accreditation process will be very time consuming. Some believe that states with accredited child welfare agencies are no better than other states that do not have the accreditation. Another concern is that the Department is very focused on meeting the Exit Plan Outcome Measures and preparing for the upcoming Child and Family Services Review, and getting ready for accreditation on top of these other efforts, could be overwhelming.

In an effort to identify any deficiencies, a comparison is currently being done part time by one DCF staff person of COA standards with current Department policies and procedures. The Director of Policy and Accreditation believes that human resources and LINK are two areas that will require significant change in order for DCF to meet COA standards. The Department has an opportunity to go through a mock COA review that would help DCF identify areas of weakness and help prepare for accreditation.

There is overlap between the COA Accreditation Standards and Connecticut *Juan F.* Exit Plan (see Appendix H). This overlap helps to assure that DCF will continue to be held to the standards addressed by the consent decree after the exit plan has been fulfilled.

Commission on Accreditation for Corrections

The American Correctional Association and the Commission on Accreditation for Corrections are private, nonprofit organizations that administer the only national accreditation program for all components of adult and juvenile corrections. The Connecticut Juvenile Training School is considering accreditation by this body as a juvenile correctional center (juvenile detention centers have different ACA standards). According to the American Correctional Association, organizations may seek accreditation to ensure that the operation is in compliance with national standards, and to demonstrate to key stakeholders that the organization is operating at acceptable professional levels. The Commission on Accreditation of Corrections is made up of 28 corrections professionals from throughout the nation to ensure that the Commission is independent and impartial. The main purpose of the Commission is to conduct accreditation hearings to verify that agencies applying for accreditation meet the relevant standards.

The association's Standards and Accreditation Department develops new standards, revises existing standards, and coordinates the accreditation process including the semi-annual accreditation hearings. The Standards and Accreditation Department also provides technical assistance to agencies and training for consultants participating in the accreditation process.

The standards are a national benchmark for the effective operation of correctional systems, addressing services, programs and operations essential to good correctional management. Operations examined pertain to:

- administrative and fiscal controls;
- staff training and development;
- physical plant;
- safety and emergency procedures;
- sanitation;
- food service; and
- rules and discipline.

The association has 21 different manuals of standards, each of which applies to a particular kind of correctional facility or program. The accreditation process usually takes up to 18 months. Accreditation is for a three year period.

All programs and facilities conduct a self-assessment of operations and complete a Self-Evaluation Report that specifies the agency's level of standards compliance. The Self-Evaluation Report is submitted to the American Correctional Association for review. A standards compliance audit can only occur if all of the mandatory standards and at least 90 percent of the non-mandatory standards are met.

The compliance audit is administered by trained American Correctional Association consultants who have an average of 18 years experience in the corrections field. The audit is usually done by three consultants during a three-day period, during which time they will look to see that the policies described in the self-assessment have actually been implemented.

An accreditation decision by the Board of Commissioners is then made. The DCF Bureau Chief for Juvenile Services estimates that there are over 400 standards, about 40 of which are

mandatory and the remaining 350 require 80 percent to be met in order for a facility to be accredited.

Accreditation hearings, which are conducted by a panel of three to five commissioners, are held three times per year at three different conferences sponsored by ACA. Concerns are addressed with the facility representatives that attend the accreditation hearing. Concerns that could prevent accreditation would be known prior to the accreditation hearing through the unofficial report given to the facility by the auditors before the leave the facility. The facility would then have the opportunity to change the audit to a "technical visit" and request an extension and re-audit six months later. Accreditation denial almost never occurs at accreditation hearings.

The Bureau Chief of Juvenile Services noted that just 33 juvenile correctional centers in the entire country are ACA accredited, and accreditation of CJTS will be a source of pride to staff, and recognition by external stakeholders.

Annual certification statements to the American Correctional Association are required once an organization has become accredited. These statements contain the following:

- current standards compliance levels, update of plans of action, significant events to include a change in the agency administration and/or major staffing changes;
- mission change or program revisions;
- changes in the offender population, including number of offenders or general offender profile;
- physical plant renovations, additions or closings; and
- any major disturbances such as extended periods of lock-down, employee work stoppages, etc.

A monitoring visit may occur during the initial three-year accreditation period to ensure continued compliance with the appropriate standards. Accredited agencies then apply for reaccreditation approximately nine months prior to accreditation expiration.

The Court Support Services Division (CSSD) went through the accreditation process for their juvenile detention centers. While the future of the Connecticut Juvenile Training School is up in the air, the Bureau Chief for Juvenile Services believes that preparation now for accreditation will serve as a foundation for future ACA accreditation regardless of whether there is a single training school or several smaller facilities. Policies and procedures are currently being compiled in preparation for ACA accreditation.

The cost of ACA accreditation for CJTS includes the direct fee paid to the American Correctional Association ($10,000), which covers the costs of three audits visiting CJTS for three days, and one CJTS staff person to attend the ACA conference to represent the facility at the hearing and to receive the accreditation. Additional costs associated with the requirements for maintaining accreditation include the assignment of one quarter to one half of the time of a manager to act as the ACA manager. The Bureau Chief noted that after the initial accreditation, the standards become part of the facility operation and the cost becomes negligible.

APPENDIX H

PNMI, DPH and Other State Regulatory Monitoring and Evaluation

CMS Reporting

Riverview Hospital has to be approved by the federal Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (CHFA). In 2000, Conditions of Participation (COPs) standards were introduced for hospitals receiving Medicaid and Medicare reimbursement.

The Centers for Medicare and Medicaid Services conduct unannounced site visits and stringent reviews. In Connecticut, the Department of Public Health performs the CMS reviews on behalf of the federal government. Riverview Hospital is also required to submit information to CMS notifying them, for example, on the purchase of a new Glucometer machine for patient testing. Riverview Hospital is also required to submit a report to CMS whenever there is an adverse reaction to medication.

The most recent unannounced CMS site visit to Riverview Hospital occurred in August 2002 prompted by an anonymous complaint made to the Hartford Courant by a staff member about the use of restraints. A team of reviewers that included representatives from the Department of Public Health, Office of the Child Advocate, and Office of Protection and Advocacy, visited seven units, reviewed patient records, staff credentials and staff training records, and interviewed staff.

According to a memo to all staff from the Superintendent of Riverview Hospital, the CMS reviewers were impressed with the hospital, commenting on the high quality of psychiatric care and facility maintenance, dedicated staff, and willingness of the administration to receive their guidance. Corrective actions identified as a result of the CMS visit included:

- staff refresher training on TACE (Therapeutic Assessment, Communication, and Education), Riverview Hospital's behavioral intervention program; to include difference between time-out and seclusion, and face-up versus face down restraints;
- improvement plan for documentation justifying restraint and seclusion use; and
- development of system to document notification of families/guardians of occurrence of a restraint or seclusion.

In a subsequent memo from the Superintendent of Riverview Hospital, remedies regarding restraint use and staffing standards were proposed including:

- the hospital administration will convene a committee to review all current hospital policies and procedures, documentation standards, etc. regarding restraint and seclusion, recommend compliance strategies, and implement new policies and procedures shortly thereafter; and

- the Director of Nursing will review the staffing pattern and determine what changes will be necessary to achieve compliance.

The hospital anticipates a CMS site visit in September 2007.

DEA Reporting

Riverview Hospital is required to maintain a controlled substance license through the federal Drug Enforcement Administration (DEA). The DEA has offices in each state and inspections conduct unannounced spot visits periodically. The visits entail a visual check of where medications are stored and secured. The last inspection occurred in May 2007 during which inspectors witnessed the destruction of controlled drugs.

DPH

In 2007, the Wilderness School was licensed as a youth camp by the Department of Public Health (DPH). The purpose of this licensure is to assure the health and safety of campers. Licensure requires adherence to 121 requirements including standards in the areas of physical plant, staff qualifications, safety and administration of medications. Licensure site visits to the Wilderness School occur annually. During the July 2007 site visit, only six requirements were not met, and the following changes were made to be in compliance with DPH licensure standards:

- Purchased six thermometers to monitor camp coolers;
- Camp physician reviewed, signed and dated weekly cases;
- Staff successfully completed waterfront module for small craft directors;
- Documented that staff had received injectable training within one year;
- Documented that staff had received oral, topical and inhalant training within three years; and
- Assistant Director will ensure that medication administration errors are reported to parents/guardians orally immediately and within writing within 72 hours.

Additionally, DPH requires the Wilderness School to report any positive medical diagnoses (e.g., strep, hospital admission).

Riverview Hospital is required to report information to DPH including infection control and immunizations. The Riverview Hospital Immunization Coordinator and Pediatrician, for example, submit all information regarding vaccinations to DPH on a monthly basis. Additionally, a form outlining treatment and follow-up care is sent to DPH whenever there is positive identification of a patient with tuberculosis.

PNMI

As non-medical facilities licensed by and that provide behavioral health services for children whose care has been authorized by DCF, therapeutic group homes and residential treatment centers participate in the Connecticut Medicaid Private Non-

Medical Institution program (PNMI). Enrollment as a PNMI Provider occurs through the execution of the Medicaid Provider and Billing Agreement Among the Connecticut Department of Social Services, DCF and performing provider of PNMI services for children. This enrollment then allows reimbursement from the federal government of 25 percent of the allowable cost of therapeutic group homes and residential treatment centers.

Three staff from PREU monitor and evaluate the PNMI requirements of the therapeutic group homes and residential treatment centers. Recent focus has been on the therapeutic group homes. There are 33 items that reviewers examine in the case records that fall into the categories of: general; need for services; treatment planning; clinical service delivery; residential service delivery; and DCF reporting. PNMI requirements, for example, include facility development of an individualized treatment plan within 30 days of admission; treatment plans that are developed in conjunction with DCF, the child, and the child's family if possible; and specific behavioral health goals and objectives within every treatment plan.

After the record review, PREU staff provides the group home or treatment center with a verbal discussion as well as a form documenting any correction required. The intent of the review is to ensure that required structures and procedures are in place. In the instance of therapeutic group homes, every record is examined during visits that occur every 1-2 months until corrections have been completed.

Appendix I
Description of Legislative Monitoring & Evaluation

Legislative oversight of state agencies is the primary function of the General Assembly's Program Review and Investigations Committee. In that role, PRI has conducted number of evaluations of the Department of Children and Families and its mandates and major programs. The General Assembly's committees of cognizance over the department, which include the legislature's Human Services and Judiciary committees, as well as the Select Committee on Children, have ongoing authority for monitoring and evaluating the department's performance and compliance with legislative intents.

A key way the legislature oversees and assesses DCF and other state agencies is through the appropriations process. The appropriations committee's recently established Results Based Accountability (RBA) project, in particular, is focused on monitoring and evaluating the progress agencies are making in achieving their policy and program goals. DCF's participation in the RBA process as well as recent DCF monitoring and evaluation activities of the Children's Committee are highlighted below

As another mechanism for tracking agency progress in meeting its goals, DCF is required by law to provide a number of reports and plans to the legislature. Current statutory reporting requirements for the Department of Children and Families are also presented below.

Children's Committee activities. In regards to DCF, the children's committee over the past five years has held a number of informational forums on areas of concern including the *Juan F*. Exit Plan, the Connecticut Juvenile Training School, and Riverview Hospital. The forums have provided committee members and other legislators with opportunities to discuss issues related to children's services in detail with officials and key program staff from DCF and other state agencies as well as representatives of various stakeholder groups (e.g., private service providers, advocates, parent organizations). The committee has also used the forums to monitor agency progress in meeting the exit plan goals and in addressing performance problems at CJTS and Riverview identified through various internal and external evaluations and investigations.

One significant resource for the children's committee oversight efforts is the Commission on Children, a legislative entity established in 1985 with 25 members representing all three branches of government, advocates for children, and private service providers and professionals who work with children. By law, the commission is responsible for: studying and providing information on the status of children and children's programs in Connecticut; and identifying programs and policies needed to improve the development of children and strengthen families.

The children's commission has focused its research and policy development efforts on prevention, particularly in the areas of early childhood and positive youth development. It views its role as advising the legislature and working in partnership with DCF and other state agencies and interest groups improve services and policies for children.

The Commission on Children has no oversight authority over DCF; its monitoring activities are limited to looking at data and general trends related to outcomes for children and

providing that information to policymakers. For example, the commission supported the development of the state's annual social health index, a tool that looks at long-term trends in 11 indicators of social well-being including child abuse, youth suicide, and high school drop out rates.

Results Based Accountability. Results Based Accountability is an approach for planning, implementing, and managing programs and policies in terms of desired outcomes and performance measures. It was developed by Mark Friedman of the Fiscal Policies Studies Institute; at present, the RBA process is used, to some extent, in over 40 states, including Connecticut.

In 2005, the General Assembly's appropriations committee co-chairs established a work group to carry out a pilot project that would try to apply the RBA framework to the state's budget process. Two program areas (early childhood education and Long Island Sound water quality) were selected for the initial test of the process during the 2006 legislative session. A consultant, The Charter Oak Group, was retained to help the work group adapt RBA principles to the legislature's appropriations process and implement the pilot project.

The main steps in the first RBA budget process included: identifying the overall program goals (i.e., "quality of life results"); developing a standard template for providing data on program results (indicators), as well as key budget information, for use during the appropriations subcommittee hearings; and subcommittee presentations by the budgeted agencies that discussed the results data and plans for improving performance (i.e., "turning the curve" to meet the program goal). After evaluating the programs according to measurable goals, committee members then could make funding decisions (either increases or cuts in appropriations) based on the results data.

Positive feedback from all participants in the pilot project led the appropriations committee to continue its Results Based Accountability approach, and expand it to include more programs and agencies, during 2007 budget process. As one of the added agencies, the Department of Children and Families applied the committee's RBA framework to four of its programs. DCF prepared templates for two programs related to the early childhood, an area targeted for inclusion by the appropriations committee work group, and for two key agency functions, foster care services and general child protection services activities.

The department noted in its budget hearing testimony to the appropriations committee that participating in the RBA process was very similar to its experience with the *Juan F.* consent decree exit plan. In fact, the program results information DCF submitted in its RBA templates for foster care and child protection includes indicators similar to several of the 22 exit plan outcome measures, as Table I-1 indicates.

The program review committee found the RBA process represents an effective mechanism for legislative monitoring and evaluation of DCF. It incorporates the best practices of continuous quality improvement: defined outcomes and standards; relevant data collection and analysis; and use of results to identify strengths and areas in need of improvement. The principles and procedures of results-based accountability also closely correspond with the main quality improvement initiatives that are underway and being planned by the department.

Table I-1. RBA Information for Selected DCF Programs, Feb. 2007

Program	Foster Care	Child Protective Services
Program Purpose	To provide for the health, safety, permanency and development of children who cannot remain in the care of their birth parents	To provide for the health and safety of children at risk of abuse, neglect, and/or maltreatment
Performance Measures	1. Percentage of children birth to 5 experiencing a single foster care placement from first entry 2. Percentage of children birth to 5 entering DCF custody who have a Multi-Disciplinary Exam (MDE) completed within 30 days of entry 3. Percentage of foster parents accessing 45 hours of training or more	1. Percent of investigations commenced in a timely manner 2. Percent of families receiving two protective services visits per month while residing at home 3. Percent of children in protective services who remain safe for 6 months 4. Number of allegations substantiated
Results	Data indicate: • Placement stability for children 0-5 varies with length of time in foster care; those in care 30 days or less experience greatest stability • Since Jan. 2006, percentage of children 0-5 with completed MDE at or above 90% (increase from under 30% in 2004) • All foster parent now complete 45 hours of training	Data indicate: • DCF has developed a timely reporting system • Steady increase in percent of families receiving twice per month visits • Percentage of children maintained safely in homes for 6 months at least 90% since Jan. 2004 • Substantiated allegations increased in some categories (physical neglect) and decreased in others (emotional neglect) between 2003 and 2005
Total Current Year Funding	$159,271, 770	$231,666,830
Funding as % of Total Agency Budget	21.1%	30.7%

At this time, results based accountability is still a pilot project within the appropriations process. For the two uses of RBA by DCF, a more comprehensive set of measures is needed; for example, the purpose of foster care is "to provide for the health, safety, permanency and development of children who cannot remain in the care of their birth parents;" yet the three measures of performance are limited to percent with single foster care placements, multi-disciplinary exams, and foster parents accessing training. The process, however, has the potential of providing legislators and the public with an objective, systematic, and comprehensive way to assess how well the department is achieving its goals.

Statutory Reporting Requirements

DCF is required by law to report on matters that cover all mandate areas of the agency as well as on agency-wide activities. Overall, there are more than a dozen different plans and reports the department must prepare and submit periodically to the legislature. Each of these statutory reports is summarized briefly below.

Agency-wide. Public Act 79-165 required DCF to prepare and submit to the legislature a five-year master plan on an annual basis; a 1986 amendment changed the plan to a biennial requirement. By law, the master plan must include: long range goals and the current level of attainment of the goals; a detailed description of the types and amount of services provided; a forecast of future service needs; a written plan for the prevention of child abuse and neglect; a comprehensive mental health plan for children and adolescents; and an overall assessment of the adequacy of children's services.

Biennial master plans including this information have never been prepared by the department. Periodically, DCF has created multi-year strategic plans that have partially addressed this requirement; the last five-year plan was produced in 2000. Now, however, the department's action plan for meeting the outcomes of the *Juan F*. consent decree exit plan considered to serve as the agency-wide strategic planning document. The committee noted this finding as a deficiency by the DCF which is addressed in an earlier recommendation.

Behavioral Health. Statutory requirements in the behavioral health mandate area date back to 1981, when quarterly hospital reports to DCF were required concerning psychiatric care. More recent legislation included reporting requirements for the KidCare program and, subsequently, a variety of evaluation and assessment reports related to the state's Behavioral Health Partnership (BHP).

At first, to meet the 1981 mandate, DCF provided monthly reports from hospitals admissions, diagnosis, discharge and demographic information to the legislature. Currently, this type of reporting is handled by the BHP's Administrative Service Organization (ASO), which began it behavioral health service authorization and utilization management functions for DCF and DSS in January 2006.

With the enactment of the KidCare program in 2000, the legislature required annual self-evaluations of the program's community care collaboratives and mandated a five-year independent longitudinal evaluation of the implementation of this children's behavioral health reform. Periodic status reports on the KidCare collaboratives and services, in addition to the outside, contracted longitudinal reports on the program were completed in accordance with statute. However, these reporting requirements was revised in 2003 and in effect replaced by a variety of Behavioral Health Partnership reports.

Under P.A. 05-280, an annual report is due each March 1 by the Behavioral Health Partnership Oversight Council (BHPOC). The current report, which includes an update by all subcommittees on their progress during the year along with the Council's recommendations, can be found on the partnership's website. Also, the BHPOC may conduct an independent external evaluation of the BHP. The RFP was recently issued for this project and a "report card" is

expected in the coming year. Additionally, the BHP must report annually to the legislative committees on the estimated cost savings of the BHP as well as provide an annual evaluation report. The first annual evaluation is expected to be completed by the end of 2007 and the partnership is still working on the methodology for determining the cost savings.

Another advisory group, the Connecticut Behavioral Health Advisory Committee (CBHAC) must provide annual reports on the local systems of care and make biennial recommendations on behavioral health services to the DCF State Advisory Council. As of August 2007, only one report, completed in 2003, had been done to meet both statutory requirements.

Protective Services. State statute (C.G.S. Section 7a-91) requires DCF to provide a report on all committed children to the legislature each year. However, 2001 was the last year for which this was completed. Additionally, DCF must establish a central registry of all children for whom a permanency plan has been formulated and in which adoption is recommended. According to the department, the intent of this report is met by the registry of children awaiting adoption found on the DCF website.

State law also requires all licensed child care facilities to submit annual reports. Standardized reports containing the following six items are provided to the department: 1. number of children currently in residence, 2. number of children in residence one-year ago, 3. number of children served during the year, 4. number of admissions during the year, 5. number of discharges during the year, and 6. number of deaths during the year. The information required in these reports is collected in a variety of other ways by the Department through licensing, contracts and the ASO and this statute entails duplicative work by the agencies.

Prevention. Annually, DCF must provide an update to OPM on its activities related to the Child Poverty and Prevention Council's 10-year plan. The agency's Director of Prevention submits annual updates on current DCF prevention programs such as the Positive Youth Development Initiative, Suicide Prevention and Prevention of Shaken Baby Syndrome to the council. The updates include long-term goals, the number of children and families served along with measurement and outcome information.

Juvenile Justice. Under C.G.S § 17a-6b, CJTS' advisory group shall provide an ongoing review of the CJTS with recommendations for improvement or enhancement. The statute outlines 9 items that must be contained in the report, including but not limited to: a review of the program and policies of the facility; the percentage of residents in need of substance abuse treatment; and demographic information of the residents. Currently the DCF prepares the report which is then reviewed by the advisory group.

Other reporting requirements. Under C.G.S. § 17a-37, DCF must provide an annual evaluation on its school district (Unified District #2) to the commissioner of education. When PRI staff inquired about these reports, the department could not document fulfilling this specific requirement. However, similar to other school districts in the state, the DCF unified district submits annual reports concerning special education services it provides and strategic school profile information to SDE.

Under another statute, C.G.S. § 17a-3 (6), DCF shall "… conduct studies of any program, service or facility developed, operated, contracted for or supported by the department in order to evaluate its effectiveness." Currently, the department partially fulfills this mandate through the program review and evaluation functions of its Bureau of Continuous Quality Improvement. However, to date, much of the bureau's focus is on residential facilities and protective services, with an emphasis on process rather than outcomes.

Since 1999, the department has been required to respond on actions taken in regard to recommendations put forth by the advisory committee promoting adoption and provision of services to minority and difficult to place children. The last year the department fulfilled this requirement was 2003 and this advising body does not exist at present.

Appendix J
Outside Investigations and Reviews

Several state entities have independent oversight roles related to children's services and the Department of Children and Families. These include the Office of Child Advocate and the Child Fatality Review Panel, both of which have statutory investigatory powers and duties related to programs and services provided to children by DCF and other state agencies. The State Attorney General, under the provisions of the state "whistleblower" law, also has investigatory responsibilities concerning reports of mismanagement or misconduct occurring in any public agency including the Department of Children and Families. The DCF monitoring and evaluation functions of all three entities are described below.

Office of Child Advocate

The Office of Child Advocate was established in 1995 to monitor and evaluate services provided to children and families by DCF and other state agencies (P.A. 95-242). Concerns over accountability for protecting children and their rights, reinforced by the tragic death of an infant in a child abuse case, led the legislature to create OCA as an independent agency with strong oversight authority.

The OCA enabling legislation also established an advisory board for the Child Advocate's office and a Child Fatality Review Panel, of which the state Child Advocate is a member. The oversight duties and activities of the Child Advocate are summarized below, followed by a description of the Child Fatality Review Panel.

Statutory requirements. The state Child Advocate is appointed by the governor from a list submitted by the OCA advisory committee and subject to legislative approval. The individual appointed to the position must have knowledge of the child welfare system and legal system and be qualified by training and experience to perform the duties of the office. These specific statutory duties include:

- evaluate delivery of services to children by state agencies and entities funded by the state;
- periodically review the procedures of state agencies providing services to children with a view towards children's rights and recommend revisions;
- review complaints concerning services provided to children, make appropriate referrals, and investigate those where a child or family are determined to need the advocate's assistance or that raise a systemic issue in state's provision of children's services;
- periodically review the facilities and procedures of any and all public and private institutions where juveniles are placed by any agency or department;
- recommend changes in state policies concerning children including changes in systems for providing juvenile justice, child care, foster care, and treatment;
- periodically review special needs children in foster care or a permanent care facility and recommend changes in placement policies and procedures for such children; and
- take all possible actions to secure and ensure legal, civil, and special rights of children who reside in Connecticut.

State statute grants the child advocate broad authority to access any information, even confidential records, necessary to carry out the office's duties. According to OCA, it is the only state agency authorized to review information from all aspects of a child's life, including DCF and court files and school and health care records. Information obtained or generated by OCA in the course of an investigation, as well as the identity of persons making reports to the advocate, is confidential and may be released by the advocate only if deemed to be in the best interest of a child or the public.

The child advocate may issue subpoenas to compel the production of books, papers, and other documents as well as the attendance and testimony of witnesses. The child advocate is also authorized to bring actions on behalf of any child before a court or state agency, provided a good faith effort has been made to resolve issues or problems through mediation. Each year, the child advocate must submit a detailed report analyzing the work of the office to the governor and legislature.

By law, the seven-member advisory committee to Office of Child Advocate[5] must meet with the advocate and OCA staff three times per year to assess:

- patterns of treatment and services for children;
- the policy implications of those patterns; and
- necessary systemic improvements.

Authorization by the advisory committee also is needed for the advocate to initiate legal actions against the state. The advisory committee is required to provide for an annual evaluation of the effectiveness of the child advocate's office. To date, this has been issued in the form of a cover letter to the OCA annual report from the committee chairman, which briefly assesses the office's accomplishments over the prior year.

In practice, the OCA advisory committee meets four times a year to help set priorities for the office and to review the status of ongoing work. The child advocate considers the multidisciplinary committee a useful resource and has called on members for their expertise and technical assistance. For example, the committee's psychologist member was asked to review and evaluate CJTS surveillance videos obtained during the OCA/AG review of that facility.

Activities. According to its annual report, the mission of the Office of Child Advocate is to oversee the care and protection of children and advocate for their well-being. Its purpose is to monitor public and private agencies that care for children and evaluate state agency policies and procedures to ensure they protect children's rights and promote their best interests.

The main activities of the child advocate's office, discussed briefly below, include: ombudsman functions; reviews and investigations of facilities and programs, and special project. In addition, OCA conducts public education and legislative advocacy, and recommends policy

[5] The seven members must include: a pediatrician, a public child welfare social worker, a representative of private children's' agencies, and a representative of education, all appointed by various legislative leaders; a Family Division judge appointed by the chief justice; a psychologist appointed by the Connecticut Psychological Association; and an attorney appointed by the Connecticut Bar Association.

changes and system reforms based on its reviews and ombudsman activities. The Child Advocate also serves on the Child Fatality Review Panel, which is described later in this section.

Ombudsman activities. A primary OCA function is to receive and review inquires and complaints from citizens about the state's child-serving systems and programs. One assistant advocate serves as the intake coordinator by screening initial calls, providing guidance and making referrals to other agencies and systems or various sources of information about available services, programs, and policies. All of the OCA professional staff share responsibility for follow up and work on cases opened for investigation. In addition to helping children and families access services and resolve problems, OCA uses its ombudsman process to identify trends and areas of concern, and to set priorities for its oversight efforts.

The numbers of calls received and cases opened by the Child Advocate's office over the past three fiscal years are shown in Table J-1. Of the approximately 1,000 contacts with the public during FY 06, about 300 calls only needed general information and around 800 calls required more follow up. Most of these calls (over 75 percent) were taken care of through referral or with additional information; OCA opened investigations for the remainder (172).

Table J-1. OCA Ombudsman Activities: FY 04 - FY 06

	FY 04	**FY 05**	**FY 06**
Total Calls Received	about 1500	about 1115	about 1000
Cases Opened (for investigation)	over 360	over 300	172

Source of Data: OCA Annual Reports, FY 04 - FY 06.

The information presented in Table J-2 is based on estimates because of limitations of the OCA call management database. While the advocate is working with the Department of Information Technology to improve the system, little progress has been made, mainly due to a lack of funding and staff resources.

It continues to be difficult for OCA to compile data on the nature of complaints received but an analysis of citizen concerns was carried out calls received in FY 04. That review found the majority of calls were made in regard to child welfare issues, most frequently about DCF child abuse investigations and case management. The second largest category of calls was legal, which involved concerns about the rights and representation of children and families in abuse and neglect proceedings but also included custody and visitation cases and sometimes the rights of children in adult criminal proceedings.

The primary concern for the mental health category, the next largest number of calls received by OCA, was access to services. Another large category of calls was related to special education, with the majority requesting help in negotiating children's individual education plans. Other, smaller areas of concern were: regular education; children's medical issues; assistance for children with mental retardation/developmental disabilities; juvenile justice matters including Families with Service Needs cases; and specific facilities, such as the Connecticut Juvenile Training School.

According to the Child Advocate, expansion of the DCF Ombudsman function beginning in 2004, has greatly assisted OCA's efforts to ensure appropriate care of at-risk children and protection of their rights. In addition, the advocate's case-specific workload has gone down over the past three years (as Table J-1 indicates), while the number of cases handled by the department's ombudsman staff has steadily grown. The DCF Ombudsman Office, based on information compiled by OCA, also has developed an accurate, effective call management system with case tracking and analysis capability.

Reviews and investigations. Since it was established, OCA has conducted 5 facility investigations, 3 of which concerned the Connecticut Juvenile Training School operated by DCF, and 6 general reviews. Seven of these studies have been carried out in cooperation with the Office of the Attorney General and one was a joint effort of OCA, DCF and the Juan F. Court Monitor. The child advocate offices also has issued a dozen in-depth reports on individual child fatalities and several follow-up reviews of child fatality investigations carried out by CFRP. All publications of the child advocate's office are listed in Table J-2.

Special projects. As part of its advocacy role, OCA carries out a wide range of special projects to protect children and promote their well-being. Recent efforts include: running a Youth Advisory Board; conducting training and technical assistance for children's' attorneys; and public education about teen dating violence. Professionals hired by and reporting to the Child Advocate also have conducted on-site monitoring at two DCF facilities (CJTS during 2003 and in 2005 to 2007, and Riverview Hospital, starting in June 2007).

In addition, OCA has initiated and/or participated in several lawsuits on behalf of children in need of mental health services and other appropriate care and treatment. During FY 04, the Child Advocate filed for, and was granted, intervener status in the recently settled *W.R.* federal court case. That case focused on ensuring that the state provides children with mental health needs with appropriate services in the least restrictive setting possible. Earlier, in December 2003, OCA filed legal proceedings against DCF for violating children's civil rights and failing to provide appropriate care and treatment in a case that became *Boy Doe, et. al. v. Department of Children and Families.*

Table J-2. OCA Publications

Facility Investigations	General Reviews	Fatality Reports	Other Publications
Riverview Hospital Joint Program Review, OCA with the Juan F. Court Monitor and DCF Bureau of Continuous Quality Improvement, Dec. 2006 *CJTS: Second Follow Up Report, OCA/AG*	*Connecticut Children Losing Access to Psychiatric Care, OCA/AG, Apr. 2007* Children with Special Health Needs: A Plan of Action, Feb. 2007 School Mobility	Child Fatality Review Panel Annual Reports, 1997-98 - 2005-06 Child Fatality Investigations of DCF, 1996 - 2003 Summary of Child	OCA Annual Reports, 1997-98 - 2005-06 Protecting Our Children: Overview of Connecticut's Child Protection System, 2002

July 2004 *CJTS: Supplemental Report, OCA/AG, Feb. 2003* *CJTS, OCA/AG, Sept. 2002* *DCF Oversight of Haddam Hills Academy, OCA/AG, May 2002*	(Educational Access for Children in Foster Care, University of Connecticut for OCA, Dec. 2005 *Investigation into DCF Hotline, OCA/AG, Sept. 2003* *The Cost of Failure: Consequences of Inadequate Community Services for Children, OCA/AG, March 2003* Services for Children with Special Health Needs, May 2001	Fatalities of Children, 1999 Child Advocate's Follow Up Report, 1999 Fatality Reports: Makayla K., 2004 Joseph Daniel S., 2003 Ezramicah H., 2002 Emily H., 2001 Alex B., 2001 Falan F. 2001 Aquan S., 1999 Andrew M., 1998 Shanice M., 1998 Ryan K., 1998 Tabatha B., 1998 Raegan M., 1997	Child Protection: Meeting the Challenges, OCA with the Judicial Department, Oct. 1999 Progress Report of the Child Advocate, Feb. 1997

Organization and resources. The OCA total estimated budget for FY 07 was just over $1 million. Most child advocate office expenses (over 80 percent) are related to its personnel costs. About $83,000 of agency FY 07 budget was allocated for activities of the Child Fatality Review Panel.

The Office of the Child Advocate had only 1.5 positions when it was established; at present, it is staffed by 10 professional and two support staff. It supplements its personnel resources with interns and volunteers, and has also pursued federal grants to support some special projects.

The associate child advocate oversees the office's investigations and ombudsman activities. One assistant child advocate serves as the intake coordinator for the office's ombudsman function and another staffs the Child Fatality Review Panel in addition to representing the office on a number of prevention-related advisory bodies and participating in various child and family prevention initiatives.

Child Fatality Review Panel

Connecticut's statutorily mandated Child Fatality Review Panel is composed of 13 permanent members including the state Child Advocate.[6] The current Child Advocate serves as the panel's chair.

[6] Panel members, who to greatest extent possible must represent the ethnic, cultural and geographic diversity of the state, are: the Child Advocate, the commissioners of DCF, DPH, and DPS, the Chief State's Attorney and the Chief

The panel was established to review the circumstances of the death of any child placed in out-of-home care, or whose death was due to unexpected or unexplained causes. The panel's scope, therefore, extends beyond children involved with DCF or other state service systems. By law, CFRP reviews have two main purposes:

1. to facilitate development of prevention strategies to address identified trends and patterns of risk: and
2. to improve coordination of services to children and families in the state.

At the request of two-thirds of the panel members, or at the advocate's discretion, OCA must conduct an in-depth investigation and issue a report on a death or critical incident (e.g., serious injury including sexual assault, life-threatening condition, human rights violation) involving a child. OCA child fatality investigation reports must be submitted to the governor, legislature, and the commissioner of any state agency cited, and made available to the general public.

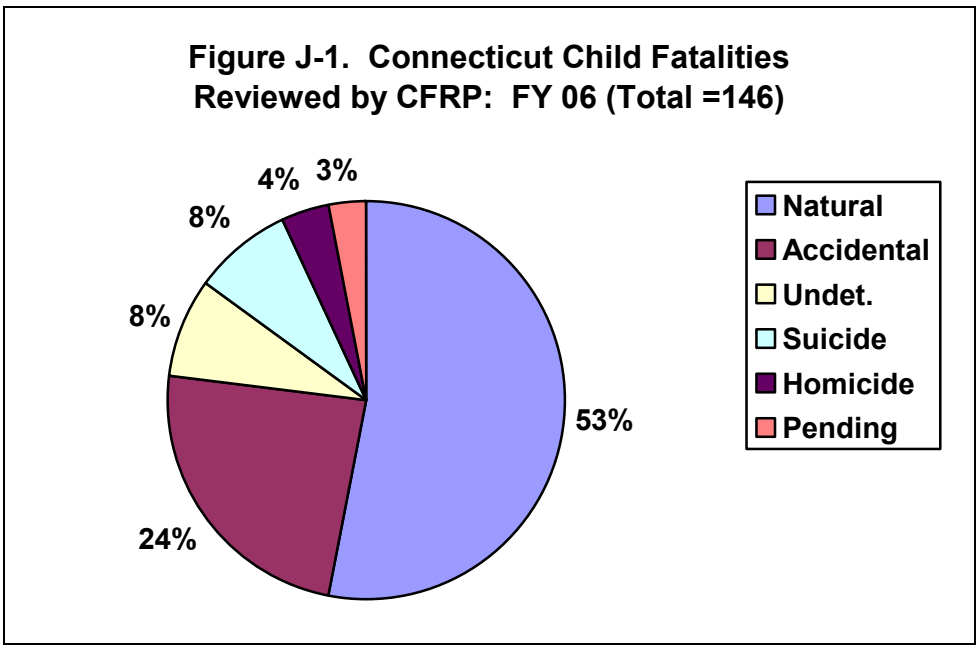
Each January 1, the panel must issue an annual report on its review of child fatalities that includes its findings, and any recommendations, to the governor and legislature. The panel, rather than producing a separate document, has included a summary of its yearly activities and proposals for change in the Child Advocate's annual report to the legislature.

Activities. CFRP reviews all child deaths reported to the child advocate with assistance of an OCA assistant child advocate. As noted earlier, that staff person carries out the day-to-day activities of the panel, which includes reviewing all reported deaths, leading in-depth investigations when determined necessary, preparing fatality investigation reports, and managing the panel's automated fatality database.

The panel meets on a monthly basis at least 10 times per year to review child fatalities reported to the state's chief medical examiner or in the media since the previous meeting. At the meeting, members are provided with a summary of facts related to each case prepared by the OCA staff person assigned to the panel. Information on any DCF involvement with the child or family, based on a review of department's child welfare computer system (LINK), is included in the summary.

In FY 06, the panel reviewed 146 child fatalities. As Figure J-1 shows, in over half of the cases (53%), the child died from natural causes. Accidental deaths accounted for 24% of the cases reviewed, and suicide or homicide was the cause of death in 11 and 6 cases, respectively. The cause of death was pending or undetermined for the remaining cases (11 percent).

Medical Examiner, or their designees; a pediatrician appointed by the governor; representative of law enforcement, a community service group, and injury prevention, and an attorney, a social work professional, and a psychologist, each appointed by a legislative leader. A majority of panel members may select not more than three additional temporary members with particular expertise or interest to serve with the same duties and powers as permanent members.



While all child deaths reported to the panel are reviewed, in-depth investigations generally are conducted only when it is determined there was, or should have been, involvement by state agencies. Since 2004, the panel has redirected its efforts to reviewing, and participating in, the child fatality investigations carried out internally by DCF rather conducting separate investigations and issuing its own on cases with DCF involvement. In addition to reducing duplication of investigatory efforts, this change reflects the panel's confidence in the quality of the department's recently revised special review process, which is carried out in conjunction with the Child Welfare League of America. A brief description of the current DCF process and the panel's participation in it follows.

DCF special review process. In response to its own concerns and those of the former Juan F. court monitor about previous internal review procedures, the department sought technical assistance, through a competitive bid process, to develop a new process based on current best practices. In April 2004, CWLA was selected to structure and help implement a review process for DCF child fatalities and critical incidents focused on improving policies and practices by providing: information for professional learning; practical feedback; and staff support.

In addition to providing expertise, and technical resources for specific reviews, CWLA has three staff persons assigned to DCF to carry out the review process. The CWLA personnel works primarily with the department's Director of Research and Development within the Bureau of External Affairs, who among other duties oversees the agency's special review process.

At present, the special review process is limited to child fatalities or critical incidents on open DCF cases and/or those closed within the previous six months. The process, which has been in place for three years, typically includes the following steps:

- Determination made by DCF senior leadership that CWLA will conduct a fatality review, usually within 48 hours of the incident; case records and a list of staff involved are forwarded to CWLA
- The Core Review Team established by CWLA; clarifies roles, timeframes, scope, and coordination with the field administrator and the DCF staff person designated as senior lead by the central office

- Entrance meeting held with field staff to provide an orientation to the process and stress reduction and debriefing
- Individual and small group interviews conducted; relevant documents and records reviewed
- Review Team drafts initial report and forwards it to staff involved with the case, the field administrator, and the designated senior lead
- Exit interview with DCF staff and the field administrator facilitated by Core Review Team to: examine the draft report for accuracy; discuss findings and recommendations; exchange feedback on the process; and create closure for the staff involved
- Revisions and modifications based on the exit interview made and final draft forwarded to central office senior leadership
- Senior leadership reviews the draft and may suggest modifications
- Final report completed within seven days, redacted for confidentiality, forwarded to the Training Academy for integration into the curriculum and placed on the department intranet for all staff
- Learning forums to discuss the case facts, key findings and recommendations, and implications for current cases, may be conducted with targeted audiences as determined by Review Team, local administrators, and central office senior leadership
- Bureau of Continuous Quality Improvement responsible for implementation of recommendations, follow-up activities, which may be coordinated with local quality improvement teams

The OCA assistant child advocate who staffs the Child Fatality Review Panel is notified by DCF of the initiation of all special reviews and attends all entrance meetings. She is authorized to participate in interviews and meetings related to the review process and has access to all materials. The OCA fatality reviewer also meets periodically with the department's research director and CWLA staff to discuss specific cases as well as systemwide issues raised by the special review process.

Both draft and final reports are reviewed by the OCA staff person and findings and recommendations, in particular, are shared with the Child Fatality Review Panel. To date, the panel has been satisfied with the process and content of the reviews carried out by CWLA and the department. No separate reports or findings and recommendations have been issued, although modifications have been made to drafts based on input from the panel and its staff.

As of November 2007, the department with CWLA, had completed 32 special reviews. The Child Fatality Review Panel, through its OCA staff person, was involved to some extent in about half of these and is participating in another seven reviews that are currently underway.

There is some concern among panel members and OCA staff about the department's heavy reliance on an outside organization to staff its internal review function. However, the CWLA process is well-regarded for its independence, high-quality research, and support for workers. Both the child welfare league and the child advocate and other CFRP members have suggested the department consider ways to expand its capacity for fatality reviews and begin to examine critical incidents on a regular basis. It has also been suggested that the threshold for

targeting cases for special review be extended from active DCF cases or those closed within six months to open cases and any others closed within twelve months of the fatality or critical incident. These matters are among the system issues the OCA fatality review staff is discussing with the department research director and CWLA consultants.

State Attorney General

The Office of the Attorney General has no general oversight authority for the Department of Children and Families or any particular state agency. Its main responsibilities regarding DCF are to: a) represent the agency in state and federal court proceedings brought on behalf of abused and neglected children's; and b) provide counseling on various civil matters including the legal sufficiency of contracts and regulations. However, through its role in whistleblower investigations, the attorney general's office also has conducted several in-depth reviews of DCF operations

The state whistleblower law allows any citizen, including state officers and employees, to provide information about fraud, corruption, waste, abuse of authority, violations of state law or regulation, unethical practices, or mismanagement in a state department or quasi-public agency, without disclosure of their identity, to the State Auditors of Public Accounts. Matters received under this statute are reviewed by the auditors and forwarded, with their findings and any recommendations, to the attorney general for appropriate investigation. At the conclusion of the investigation, the attorney general, where necessary, reports any findings to the Governor, or in the case of criminal necessary activity, to the Chief State's Attorney.

Limited staff resources require the attorney general's staff to prioritize its investigation projects. (Only about a dozen lawyers are dedicated to the functions of the office's whistleblower/healthcare fraud/health insurance advocacy department.) In general, only whistleblower cases with substantial public interest concerns or evidence of system-wide failures are selected for a full investigation.

Since 2002, the attorney general has issued investigative reports on five matters related to DCF based on whistleblower complaints. These include: the department's oversight of a private residential treatment provider (Haddam Hills Academy); operations of the Connecticut Juvenile Training School, which involved an initial investigation and two follow-up reviews; the adequacy of community-based services for children; the DCF Hotline system; and children's access to psychiatric care. All were carried out in conjunction with the Office of the Child Advocate.

The attorney general's partnership with OCA began when the Child Advocate requested assistance in gathering evidence for its own review of Haddam Hills Academy at the same time the OAG's whistleblower unit was reviewing allegations of mismanagement at the facility. Recognizing that each office could benefit from the other's special expertise (e.g., OAG staff had experience with the subpoena process while OCA staff were familiar with department computer systems), the child advocate and the attorney general decided to conduct a joint investigation and have continued to work together on topics related to children and families.

Appendix K
Description of Advising Bodies

As noted in the September briefing report, a number of committees, commissions and boards, established in accordance with state and federal law, have responsibility for advising and assisting DCF on matters within the department's purview. Advisory groups provide an agency or group to which they are advising, external perspective on areas or issues needing improvement. Recommendations for improvement, both informal and formal, are often a result of advising activities.

The PRI study focused on the monitoring and evaluation roles of the formal advisory groups that provide input directly to DCF, including those created for department-operated facilities. The program review study also examined the activities of several statutory bodies that require DCF participation in providing advice to the legislature or governor on policies and service for children at risk, such as the Child Poverty and Prevention Council, the Families with Service Needs Advisory Board, and the Governor's Task Force on Justice for Abused Children.

In addition, there appear to be a number of informal advisory bodies that are influential to different areas of the agency. For example, CJTS has a youth advisory board composed of youth at the facility who make recommendations regarding day-to-day practices at the facility. Additionally, a youth advisory board composed of children from the various therapeutic group homes convenes monthly and makes recommendations concerning home life in addition to planning outings and activities for the youth residing in the homes. Although these ad hoc advisory boards provide an important outlet for the children to improve the system, the PRI study focused on advisory groups required by either state or federal law.

Overview

All 15 state and federally mandated DCF advisory bodies are summarized in Table K-1 and each is described in more detail below.

As Table K-1 indicates, some groups are intended to serve only in an advisory capacity, some are required to provide written recommendations or produce reports and in a few cases, the advisory body by law has specific monitoring and evaluation authority (i.e. BHPOC).

Most of the advising bodies were created a number of years ago, although four were created in the past 7 years. Most of the groups meet on a monthly basis. However, two advisory groups are currently inactive.

Group membership also varies. Many require representatives from state agencies, members of the community, parents, and appointments by the Governor.

Table K-1. Advising Bodies			
Advisory body	**Role**	**Members/ Appt**	**Status**
State Advisory Council (SAC) – *estb. by state law 1971*	• Make recommendations to improve services • Annually advise on agency budget	17 members appointed by the governor	Meet quarterly
Area Advisory Councils – *estb. by state law 1975*	• Advise in planning and implementing appropriate and effective services	Composed of no more than 21 persons	Meet monthly
Children's Behavioral Health Advisory Council (CBHAC) – *estb. by state law 2000*	• Make recommendations to SAC on the provision of behavioral health services • Monitor, review and evaluate the provision of state dollars for children's mental health services	• 8 ex-officio members • 8 gubernatorial and legislatively appointed public members • 16 public members appointed by the Advisory Council chairperson	Meet monthly
Connecticut Behavioral Health Partnership Oversight Council (BHPOC) –*esbt. by state law* 2005	• Assess the development and ongoing implementation of the BHP program • Make recommendations • Review and comment on the contract between DSS and DCF and the ASO • Review delivery of mental health services to assure maximum federal contribution	12 legislative committee chairs and ranking members, DMHAS commissioner, Member for the Community Mental Health Strategy Board, 16 members representing providers, consumers, and experts appointed by the chairs of the Medicaid Managed Care Advisory Council, at least nine ex-officio members	Meet monthly
CJTS Public Safety Committee – *estb. by state law 1999*	• Review safety and security issues that affect host community	School superintendent and representatives appointed by the mayor	Inactive
Families With Service Needs Advisory Board – *estb. by state law 2006 but will terminate Dec 31, 2007*	• Monitor progress of DCF in developing services for girls • Monitor implementation of PA05-250 • Make recommendations	Consists of 20 members	Meet monthly
Citizen Review Panel - *Federal mandate*	• Evaluate the extent to which the state is fulfilling its child protection responsibilities in accordance with its federal CAPTA plan	2007 membership currently 66% parents/consumers and 33% agency, representing geographic and ethnic diversity across the state	
Governor's Task Force on Justice for Abused Children – *estb. by state law 1996*	• Monitor and evaluate multidisciplinary teams established under 17a-106a	Co-chaired by the Chief State's Attorney and Commissioner of DCF. Comprised of parents, citizen advocates and professionals	Meet monthly
Advisory Committee Promoting Adoption and Provision of Services to Minority and Difficult to Place Children – *estb. by state law 1999*	• Make recommendations	No members	Inactive
Youth Suicide Advisory Board – *estb.. by state law 1989*	• Make recommendations • Develop strategic youth suicide prevention plan	Consist of 20 members	Meets every other month
Child Poverty and Prevention Council – *Prevention Council esbt. by state law in 2001 and merged with Child Poverty Council in 2004*	• Develop 10-yr plan to reduce child poverty • Establish prevention goals, outcome measures to promote health and well-being of children and families	Comprised of OPM, DCF, DSS, DOC, DMR, DMHAS, SOT, DPH, SDE, DECD, OHCA, DOL, BOGHE, OCA, Prevention Council, Children's Trust Fund, Commission on Children and Legislative appointees	Meet monthly
DCF Institution/Facility Advisory Groups – *estb. by state law 1971*	• Advise the facility	Varies by facility	Varies by facility

Agency-wide and Area Advisory Groups

Area Advisory Councils. As required by statute, the commissioner of DCF must create "an area advisory council to advise the commissioner and the area director on the development and delivery of services of the department in that area and to facilitate the coordination of services for children, youths and their families in the area." Currently DCF has 13 area advisory councils. The council must not consist of more than 21 people the majority of whom shall be person who earn less than 50 percent of their salaries from the provision of services to children, youths and their families, and the balance representative of private providers of human services throughout the area. State statute has specific guidelines on term limits and requires they meet at least quarterly.

Each of the 13 area advisory councils set their own agendas and therefore they all operate differently. For example, the Norwich and Willimantic Area Advisory councils held community and provider forums respectively, in which recommendations were made to the area office and practice changes occurred. On the other hand, the Waterbury Area Advisory council grew out of the Casey Breakthrough series and focuses their activities on delivering prevention services to an elementary school.

State Advisory Council. The State Advisory Council is legislatively mandated to meet quarterly but in recent years has met on a monthly basis. Council members are appointed by the Governor. By law the Council membership must include persons who are child care professionals, one child psychiatrist, and at least one attorney. The remaining members must represent young persons, parents and others interested in the delivery of services to children and youth.

The commissioner of DCF, according to C.G.S. § 17a-6(m), shall "submit to the state advisory council for its comment proposals for new policies or programs and the proposed budget for the department." Currently this does not occur. Additionally, the statutes are silent as to the council's primary purpose. Therefore, for the upcoming year, the SAC co-chairs decided the committee would focus on ways to improve the foster care system. In addition, the chairs want to coordinate advising activity that goes on across the state.

DCF Facility Advisory Boards

According to statute, the commissioner "may appoint advisory groups" for any DCF run facility. Currently, CJTS, Riverview Hospital and High Meadows have active advisory groups.

CJTS. The CJTS advisory board meets monthly at the facility. Members of the group include representatives from: community providers, the public defender's office, the mayor of Middletown, and juvenile court among others.

At each meeting the staff of CJTS present facility updates and distributes a summary report on critical incidents. The members of the board actively participate in offering suggestions on different ways to look at the data to understand trends, as well as offer feedback on services

and programs occurring at the facility. The board serves as an informal mechanism for providing feedback to the facility. In addition to the informal feedback, statute requires the board to submit an annual report to the legislature. Staff of the facility initially prepares the report which then gets reviewed by the board. The board then develops recommendations which get included in the report.

Riverview. Riverview Hospital's advisory board activity has ebbed and flowed in the past few years. After many months of not meeting, the hospital's board was reinstated by the new acting superintendent in January 2007. Prior to her appointment, the advisory board lacked clear direction and was composed mostly of DCF employees. The board recently appointed a chair and is in the process of formalizing its structure and reaching out to expand the diversity of its membership. The advisory board in the upcoming year will be focusing on monitoring progress with the Strategic Plan and working on developing relationships between Riverview Hospital and the community.

High Meadows. The Citizen Advisory board for High Meadows was initially established due to community concerns. They meet on a quarterly basis but have not met since January 2007. However, in the past the group has provided suggestions to facility staff operating in a more informal manner.

Although, not formally required by statute, High Meadows also has a youth advisory board that meets on a monthly basis. Each cottage has q-w representatives. They meet with the Ombudsman, intake worker, and cottage supervisor. It is like a student council at a public school where they focus on issues related to activities, food, rules, and community living.

Connecticut Children's Place. The CCP advisory board has not met since September 2005.

Citizen Review Panel. Under federal CAPTA legislation (Child Abuse Prevention and Treatment Act), CT is required to establish a minimum of three Citizen Review Panels. Currently there are two groups that serve as the citizen review panels comprised of groups of parents and professionals who have personal or professional experience with DCF. Each panel must evaluate the extent to which the State is fulfilling its child protection responsibilities in accordance with its CAPTA state plan. This includes (1) examining the policies, procedures and practices of state and local child protection agencies, and (2) reviewing specific cases, where appropriate. In addition, consistent with sections 106(c) (4) (a) (iii) of CAPTA, a panel may examine other criteria that it considers important to ensure the protection of children, including the extent to which the state and local CPS system is coordinated with the title IV-E foster care and adoption assistance programs of the Social Security Act (Section 106(c) (4) (A) and (ii)).

In order to assess the impact of current procedures and practices upon children and families in the community and fulfill the above requirements, citizen review panels must provide for public outreach and comment (section 106(c) (4) (C) of CAPTA). Finally, each panel must prepare an annual report that summarizes the activities of the panel and makes recommendations to improve the CPS system at the State and local levels, and submit it to the State and the public (section 106(c) (6) of CAPTA).

In 2005, DCF contracted with FAVOR, Inc., a statewide family advocacy organization for children's mental health, to administer two Citizen Review Panels. In 2006, two panels were organized to review policies, procedures and other relevant material as it pertains to DCF protective services. The panel membership was roughly divided into Northern and Southern parts of the state. Additionally, seven forums were held throughout the state to gather community feedback of DCF services and programs.

In 2007, the Citizen Review Panels administered by FAVOR did not hold the community forums but instead took a more focused approach.

Yet both must annually report to the commissioner findings and recommendations on areas of particular concern.

Issue-Specific Advisory Groups

Connecticut Behavioral Health Advisory Council (CBHAC). CBHAC, originally a subcommittee of the State Advisory Council that addressed systems of care issues, was formally established under P.A. 00-188 and now serves in an advisory capacity to the State Advisory Council. According to the statute, CBHAC must

Under the requirements of P.A. 00-188:

- CBHAC is composed of state agency appointments (commissioners or their designees), state legislature appointments, two members appointed by the Governor, and 16 members appointed by the State Advisory Council on Children and Families;
- The majority of members must be "parents or relatives of a child who has or had a serious emotional disturbance or persons who had a serious emotional disturbance as a child" and appointed members being limited to two two-year terms;
- Members serve two-year terms;
- CBHAC is chaired by two persons from its members—at least one of which is a parent of a child with serious emotional disturbance—who serve two-year terms and may be re-nominated;
- CBHAC meets at least bimonthly;
- CBHAC is to submit an annual status report on local systems of care and practice standards; and
- CBHAC is to submit biannual "recommendations concerning the provision of behavioral health services for all children in the state" to the State Advisory Council. CBHAC members also review the Mental Health Block Grant and submit recommendations which accompany the grant.

The advisory council has spent the past six months advising its by-laws in an attempt to put more structure around the council's activities. The by-laws were approved in the September 2007 meeting. As part of the new by-laws, the Council has decided to send their monthly minutes to the SAC which contain recommendations to allow for more timely communication between the committees. DCF supports the committee by providing a staff person to take minutes and publish agendas. The committee maintains strong parent involvement.

Youth Suicide Advisory Board. The Youth Suicide Board was created by P.A. 89-191 and was created to exist within the Department of Children and Families. As outlined in statute the board must consist of 20 members. The statute specifies the members must include each of the following: a psychiatrist, a psychologist, a representative from a local or regional board of education, a high school teacher, a high school student, a college or university faculty member, a college or university student, a parent, a DPH representative, a DOE representative, and a representative from the Department of Higher Education. Additionally the statute outlines 7 requirements of the board:

- Increase public awareness of the existence of youth suicide and means of prevention;
- .make recommendations to the commissioner for the development of state-wide training in the prevention of youth suicide;
- develop a strategic youth suicide prevention plan;
- recommend interagency policies and procedures for the coordination of services for youths and families in the are of suicide prevention;
- make recommendations for the establishment and implementation of suicide prevention procedures in schools and communities;
- establish a coordinated system for the utilization of data for the prevention of youth suicide;
- make recommendations concerning the integration of suicide prevention and intervention strategies into other youth-focused prevention and intervention programs.

The Director of Prevention for DCF runs the board which is funded by both DCF and the Mental Health Block Grant. Each year the board submits recommendations to the commissioner. Those recommendations are implemented and tracked by the board and DCF.

Inactive DCF Advisory Groups

The Advisory Committee Promoting Adoption and Provision of Services to Minority and Difficult to Place Children currently does not exist although it is written in statute. When initially established in 1999, the body was active and met quarterly. In 2002, the Minority Recruitment Council was merged with the Community Collaboratives. There are 5 collaboratives comprised of members of the community and DCF that look at recruitment and retention of Foster Care families. Each collaborative must do outreach to specific minority groups with recruitment efforts focusing on the need for placement for minority children. Although oversight of all the

activities of the collaboratives includes a focus on minority recruitment a separate effort does not exist.

Under state statute a public safety committee should be established to review safety and security issues that affect the host community where CJTS resides. The membership must be composed of the school superintendent and an unspecified number of representatives appointed by the mayor. However, this committee does not exist but the function has essentially been taken over by the CJTS advisory board where the Mayor of Middletown is a member.

Advisory Groups Requiring DCF Participation

Behavioral Health Partnership Oversight Council. In 2005, the Oversight council to the Behavioral Health Partnership was created. Statute clearly defines the membership requirements. In addition to the chairpersons and ranking member of the joint standing committees of the General Assembly having cognizance of matters relating to human services, public health, appropriations and the budgets of state agencies, state statute requires 27 additional members who must fulfill specific criteria such as 'a child psychiatrist serving HUSKY children."

The Oversight Council is organized into 5 subcommittees: Coordination of Care, Quality Management and Access, Provider Advisory, Operations, and DCF Advisory. Each of the subcommittees as well as the oversight council meets on a monthly basis.

The Council also has specific reporting and monitoring requirements. Annually, the council must submit a report on the council's activities and progress. Additionally the council must make specific recommendations on matters related to the planning and implementation of the Behavioral Health Partnership which shall include, but not limited to:

- Review of any contract entered into the DCF and DSS with an administrative services organization, to assure that the administrative service organization's decisions are based solely on clinical management criteria developed by the clinical management committee;
- review of behavioral health services pursuant to Title XIX and Title XXI of the Social Security Act to assure that federal revenue is being maximized;
- review of periodic reports on the program activities, finances and outcomes, including reports from the director of the Behavioral Health Partnership on achievement of serve delivery system goals.
- The council may conduct or cause to be conducted an external, independent evaluation of the BHP

Governor's Task Force on Justice for Abused Children. The Governor's Task Force on Justice for Abused Children, first established in 1988, focuses on coordinating multidisciplinary teams that coordinate in the beginning stages of a child abuse or neglect investigation. A designee each from the Department of Children and Families and from the Division of Criminal Justice co-chairs the committee. Other members of the task force include

but not limited to designees from Office of the Public Defender, Office of the Attorney General, and Office of the Child Advocate. In addition representatives from the following groups serve on the task force: a parent, a health professional, parent group representative, disabled children's advocate, and a private practice clinician. The task force receives federal funding from the Children's Justice Act Grant.

In 2002, in accordance with C.G.S. § 17a.-106a(c), a permanent Multidisciplinary Team (MDT) Evaluation Committee was established to review protocols and monitor and evaluate the performance of MDT's and make recommendations for modification to the system.

Child Poverty and Prevention Council. In June 2006, the active Child Poverty Council and the inactive Prevention Council were combined into one advising body. The purpose of the newly formed Child Poverty and Prevention Council was to:

Develop and promote the implementation of a ten-year plan to reduce the number of children living in poverty in the state by 50 percent and

Establish prevention goals and recommendations and measure prevention service outcomes to promote the health and well-being of children and families.

Prior to the two councils joining, the Child Poverty Council had created a ten-year plan to reduce child poverty which contained 67 recommendations for executive and legislative branch consideration. Annually, the council produces a report containing a progress update on the actions taken to-date. The Council is overseen by the Office of Policy and Management with a representative from DCF sitting on the council. Yearly, DCF submits a progress report on the programs they had identified as prevention only programs.

Families with Services Needs. According to P.A. 06-188, the Families With Service Needs Advisory Board shall (1) monitor the progress being made by the Department of Children and Families in developing services and programming for girls from families with service needs and other girls, (2) monitor the progress being made by the Judicial Department in the implementation of the requirements of P.A. 05-250, (3) provide advice with respect to such implementation upon the request of the Judicial Department or the General Assembly, and (4) not later than December 31, 2007, make written recommendations to the Judicial Department and the General Assembly, in accordance with the provisions of C.G.S. § 11-4a, with respect to the accomplishment of such implementation by the effective date of P. A. 05-250. The board shall terminate on December 31, 2007.

The board meets monthly and is supposed to be composed of 20 members; however, the Governor's appointment remains unfilled.

Appendix L

Information Collected and Analyzed for Selected Types of Monitoring/Evaluation Efforts

Table L-1. Information Collected for Selected Types of Monitoring and Evaluation Effort	
Type of Effort	Information Collected
Performance Based Contracts (n=8)	▪ Contractors submit data reports on a monthly or quarterly basis to DCF ▪ Bed capacity, number of homes available for placement ▪ Number of participants ▪ Demographic information ▪ Self-efficacy pre and post tests ▪ OHIO scale
Contracted Evaluations (n=16)	▪ Providers submit data to Yale Child Study Center on a monthly basis ▪ Families' satisfaction with services based on a standardized assessment tool. ▪ Children's characteristics, behavioral health services received over past ▪ Barriers to accessing services and respondents' familiarity with DCF program ▪ OHIO scales done at intake and discharge
Internal Studies (n=4)	▪ Information related to concerns about facility/service ▪ Feedback from families on service received ▪ Exploration into why enrollment in 20 day expeditions is down
Planning Efforts (n=7)	▪ Many of the objectives are tied to Juan F Exit Outcome Measures, which are tracked internally on LINK and ROM, and by OCM reports ▪ The permanency planning task force identified internal and external needs and challenges ▪ Measured whether programs/policies were implemented and actions taken
Licensing (n=7)	▪ Sleeping accommodations, lavatory facilities, kitchen, equipment, food-handling ▪ Health and medical treatment; medication administration guidelines ▪ Personnel policies ▪ Case records, reports, confidentiality ▪ Treatment plan review; discharge summary ▪ Assessment of foster or prospective adoptive parents and members of household

Type of Effort	Information Collected
Juan F Outcome Measures (n=22)	▪ Number of children in over capacity homes ▪ Children who come into care during each quarter ▪ length of time from removal to reunification (used AFCARS discharge methodology) ▪ Data on visits to all out-of-home and in-home cases
Federal Grant Requirement (n=8)	▪ Scales to assess child behavior, functioning, satisfaction ▪ Cultural sensitivity, access to care, participation in treatment planning ▪ Number of substance abusing adolescents served ▪ Presence of grant-required activities
Federal Child Welfare Outcomes (n=6)	▪ Maltreatment in foster care ▪ Percent of children who exited foster care to a finalized adoption in less than 24 months from the time of the latest removal from home ▪ Number of placements by time in care
Investigations-Child Fatalities-OCA (n=3)	▪ Services received ▪ Police and legal involvement ▪ Health information ▪ Family member information
Investigations/Studies OCA (n=7)	▪ Observe hospital operations/patient care units ▪ Interact with children and staff ▪ CJTS records ▪ Medical information ▪ Incident reports ▪ Behavioral plans and treatment plans ▪ Videotapes
Advising Bodies (n=11)	▪ Contracts and training curriculum ▪ Policies, procedures, statutes, regulations, data and other relevant materials ▪ Quarterly reports with foster parent recruitment and retention data

Table L-2. Way in Which Information is Analyzed for Selected Types of Monitoring and Evaluation Effort	
Type of Effort	Way in Which Information Analyzed
Performance Based Contracts (n=8)	▪ Aggregate information into simple demographic descriptive reports
Contracted Evaluations (n=16)	▪ retrospective longitudinal record review ▪ Randomly selected sample of children ▪ Conducted telephone interviews ▪ Looked at clinical outcomes, fidelity measures, and results of group and individual supervision with each team ▪ Compile and produce quarterly reports ▪ Analyzed utilization data, web-based record review and evaluation, and site visits by site consultants
Internal Studies (n=4)	▪ Team of 8, including DCF, OCA and Court Monitor staff, spent 6 months at Riverview Hospital, observing (2,432 hours), interviewing 84 staff and 24 children, attending 104 meetings ▪ Used surveys and focus groups that were designed by the EDT Practice Standards Committee ▪ Site visit observations, staff survey questionnaires, resident interviews, observations in "natural meetings", focus groups with external professionals, review of policies and procedures
Planning Efforts (n=7)	▪ Established 3 separate subcommittees: 1) investigation services and permanency planning; 2) policy and permanency planning; 3) treatment and permanency planning. ▪ Didn't measure, took action. Developed a strategic plan with input from national experts ▪ Reviewed info on services available and best practices and research. Interviewed girls in DCF and CSSD funded programs
Licensing (n=7)	▪ Two inspectors from DCF licensing unit make site visits to program ▪ Site visits occur every two years for re-licensing inspection ▪ Observations are compared to standards; any areas out of compliance require correction prior to re-issuing of license

Type of Effort	Way in Which Information Analyzed
Juan F Outcome Measures (n=22)	▪ Query of the LINK database ▪ Access ROM reports ▪ Produce aggregate quarterly reports on each of the 22 outcome measures ▪ Case review done quarterly by OCM-select a representative sample, including all area offices; in accordance with methodology outlined in exit plan as modified in 2006
Federal Grant Requirement (n=8)	▪ Required SAMHSA site visits in Years 2 and 4 (conducted a series of focused discussions with staff and community partners) ▪ 10-15 minute telephone survey for the caregivers of children who have received services from the publicly funded behavioral health system ▪ To identify areas that would benefit from technical assistance activities ▪ Developed logic model
Federal Child Welfare Outcomes (n=6)	▪ AFCARS Annual Foster Care Database ▪ NCANDS child file ▪ Intensive case reviews, interviews and focus groups with stakeholders in the state and state self-assessment reports
Investigations-Child Fatalities-OCA (n=3)	▪ Extensive interviews with professional and paraprofessional persons involved with children and families including: DCF personnel; private service providers; courts; police; legal; medical professionals; and family ▪ Review of DCF, providers, health, legal, and police records ▪ Review of literature review and professional standards
Investigations/Studies OCA (n=7)	▪ Examined written documents including legislative info and Rowland impeachment hearings ▪ Produce quarterly progress reports for Child Advocate and discuss with Commissioner ▪ Extensive interviews with professional staff at CJTS, managers, medical and nursing staff, mental health clinicians, educational staff, administrative staff, administration and youth ▪ CONDOIT data
Advising Bodies (n=11)	▪ Review of contracts and training curriculum ▪ Held listening forums led by facilitators; DCF and Advisory Council members listened and recorded responses ▪ Held two annual community collaborative conferences

APPENDIX M

Information Collected and Analyzed for Internal Monitoring & Evaluation Efforts

Table M-1. Information Collected for Selected Types of Internal Monitoring and Evaluation Efforts

Type of Internal Effort	Examples of Information Collected
Performance Based Contracts (n=8)	▪ Contractors submit data reports on a monthly or quarterly basis to DCF ▪ Bed capacity, number of homes available for placement ▪ Number of participants ▪ Demographic information ▪ Self-efficacy pre and post tests ▪ OHIO scale
Contracted Evaluations (n=16)	▪ Providers submit data to Yale Child Study Center on a monthly basis ▪ Families' satisfaction with services based on a standardized assessment tool. ▪ Children's characteristics, behavioral health services received over past ▪ Barriers to accessing services and respondents' familiarity with DCF program ▪ OHIO scales done at intake and discharge
Internal Studies (n=4)	▪ Information related to concerns about facility/service ▪ Feedback from families on service received ▪ Exploration into why enrollment in 20 day expeditions is down
Planning Efforts (n=7)	▪ Many of the objectives are tied to Juan F Exit Outcome Measures, which are tracked internally on LINK and ROM, and by OCM reports ▪ The permanency planning task force identified internal and external needs and challenges ▪ Measured whether programs/policies were implemented and actions taken
Licensing (n=7)	▪ Sleeping accommodations, lavatory facilities, kitchen, equipment, food-handling ▪ Health and medical treatment; medication administration guidelines ▪ Personnel policies ▪ Case records, reports, confidentiality ▪ Treatment plan review; discharge summary ▪ Assessment of foster or prospective adoptive parents and members of household
Research Unit/Special Investigations (n=3)	▪ Examined/analyzed 5 core areas: 1) implementation of DCF's mission, guiding principles and practices; 2) case practice; 3) supervision and training; 4) internal policies and procedures; 5) larger systems.
Internal Miscellaneous (n=7)	▪ Information in ACT database includes area office, facility, DOC, reasons for inquiry, contact type and contact method ▪ Quarterly reports compiled based on LINK data, ROM reports ▪ Monthly critical incident data, staff climate survey, youth climate survey, youth exit interview, and youth record review

Table M-2. Way in Which Information is Collected/Analyzed for Selected Types of Internal Monitoring and Evaluation Effort	
Type of Internal Effort	Way in Which Information Collected/Analyzed
Performance Based Contracts (n=8)	▪ Aggregate information into simple demographic descriptive reports
Contracted Evaluations (n=16)	▪ retrospective longitudinal record review ▪ Randomly selected sample of children ▪ Conducted telephone interviews ▪ Looked at clinical outcomes, fidelity measures, and results of group and individual supervision with each team ▪ Compile and produce quarterly reports ▪ Analyzed utilization data, web-based record review and evaluation, and site visits by site consultants
Internal Studies (n=4)	▪ Team of 8, including DCF, OCA and Court Monitor staff, spent 6 months at Riverview Hospital, observing (2,432 hours), interviewing 84 staff and 24 children, attending 104 meetings ▪ Used surveys and focus groups that were designed by the EDT Practice Standards Committee ▪ Site visit observations, staff survey questionnaires, resident interviews, observations in "natural meetings", focus groups with external professionals, review of policies and procedures
Planning Efforts (n=7)	▪ Established 3 separate subcommittees: 1) investigation services and permanency planning; 2) policy and permanency planning; 3) treatment and permanency planning. ▪ Didn't measure, took action. Developed a strategic plan with input from national experts ▪ Reviewed info on services available and best practices and research. Interviewed girls in DCF and CSSD funded programs
Licensing (n=7)	▪ Two inspectors from DCF licensing unit make site visits to program ▪ Site visits occur every two years for re-licensing inspection ▪ Observations are compared to standards; any areas out of compliance require correction prior to re-issuing of license
Research Unit/Special Investigations (n=3)	▪ Held focus groups with case review teams from the CM's office, meetings with OCA and ombudsman's office ▪ Interviewed staff and family ▪ Reviewed case records ▪ Reviewed relevant child welfare research ▪ Analyzed findings and recommendations to identify themes and critical relationships
Internal Miscellaneous (n=7)	▪ Report compared two calendar years ▪ Forecasting to anticipate which children will be at limit for timetable 3 months prior ▪ Program lead makes site visits to providers to assess compliance with requirements in contract and licensing regulations; include interviews with clients, staff; observation; case record review

APPENDIX N

Information Collected and Analyzed for External Monitoring & Evaluation Efforts

Table N-1. Information Collected for Selected Types of External Monitoring and Evaluation Efforts

Type of External Effort	Examples of Information Collected
Juan F Outcome Measures (n=22)	▪ Number of children in over capacity homes ▪ Children who come into care during each quarter ▪ length of time from removal to reunification (used AFCARS discharge methodology) ▪ Data on visits to all out-of-home and in-home cases
Court-Other (n=5)	▪ status conferences, site visits, meeting with departments ▪ narratives of cases with change in goal ▪ what happened after entered DCF custody ▪ time spent on each step of process including court activities
Governor, Legislature-Driven (n=4)	▪ Gathered data from CONDOIT ▪ Percent of investigations commenced in timely manner ▪ Numbers of allegations of abuse/neglect sustained ▪ Discharge process
Federal Grant Requirement (n=8)	▪ Scales to assess child behavior, functioning, satisfaction ▪ Cultural sensitivity, access to care, participation in treatment planning ▪ Number of substance abusing adolescents served ▪ Presence of grant-required activities
Federal Child Welfare Outcomes (n=6)	▪ Maltreatment in foster care ▪ Percent of children who exited foster care to a finalized adoption in less than 24 months from the time of the latest removal from home ▪ Number of placements by time in care
Accrediting Body, External Licensure, PNMI/Medicaid (n=4)	▪ Assess adherence with PNMI standards ▪ Physical plant, staff qualifications, safety and administration of medications ▪ Need for services; treatment planning; clinical service delivery
Federal Requirements-Other (n=4)	▪ Strengths and areas in need of improvement ▪ Whether child meets statutory eligibility requirements for foster care maintenance payments ▪ Verify that the electronic data submitted to AFCARS matches the data in the paper files

Table N-2. Way in Which Information is Analyzed for Selected Types of External Monitoring and Evaluation Effort	
Type of External Effort	Way in Which Information Analyzed
Juan F Outcome Measures	▪ Query of the LINK database ▪ Access ROM reports ▪ Produce aggregate quarterly reports on each of the 22 outcome measures ▪ Case review done quarterly by OCM-select a representative sample, including all area offices; in accordance with methodology outlined in exit plan as modified in 2006
Court-Other	▪ Court monitor hired to monitor progress and report on implementation ▪ Retrospective LINK data, focus groups, discussion groups, and statute and record reviews ▪ Analysis of demographics and timeliness for random sample
Governor, Legislature-Driven	▪ Parole supervisors completed case reviews ▪ Data from LINK and ROM systems
Federal Grant Requirement	▪ Required SAMHSA site visits in Years 2 and 4 (conducted a series of focused discussions with staff and community partners) ▪ 10-15 minute telephone survey for the caregivers of children who have received services from the publicly funded behavioral health system ▪ To identify areas that would benefit from technical assistance activities ▪ Developed logic model
Federal Child Welfare Outcomes	▪ AFCARS Annual Foster Care Database ▪ NCANDS child file ▪ Intensive case reviews, interviews and focus groups with stakeholders in the state and state self-assessment reports
Accrediting Body, External Licensure, PNMI/Medicaid	▪ Periodic site visits by PREU staff ▪ On site visit occurs annually by a DPH inspector ▪ In-depth self-study ▪ "Tracer methodology" that traces a child's stay from admission to discharge
Federal Requirements-Other	▪ Whether DCF conforms with national standards ▪ States are rated on a scale of 1-4 for each systemic factor ▪ The federal Children's Bureau conducts assessment reviews

APPENDIX O

Information Collected and Analyzed for Investigative Monitoring & Evaluation Efforts

Table O-1. Information Collected for Monitoring and Evaluation Efforts	
Type of Effort	Information Collected
Investigations-Child Fatalities- (n=3)	▪ Services received ▪ Police and legal involvement ▪ Health information ▪ Family member information
Investigations/Studies-OCA (n=7)	▪ Observe facility operations ▪ Interviews with children and staff ▪ Facility records ▪ Medical information ▪ Incident reports ▪ Individual treatment plans ▪ Videotapes

Table O-2. Way in Which Information is Analyzed for Monitoring and Evaluation Efforts	
Type of Effort	Way in Which Information Analyzed
Investigations-Child Fatalities	▪ Extensive interviews with professional and paraprofessional persons involved with children and families including: DCF personnel; private service providers; courts; police; legal; medical professionals; and family ▪ Review of DCF, providers, health, legal, and police records ▪ Review of literature review and professional standards
Investigations/Studies-OCA	▪ Examined written documents including legislative info and Rowland impeachment hearings ▪ Produce quarterly progress reports for Child Advocate and discuss with Commissioner ▪ Extensive interviews with professional staff at CJTS, managers, medical and nursing staff, mental health clinicians, educational staff, administrative staff, administration and youth ▪ CONDOIT data

Appendix P
AFCARS Assessment Review Description and Results

AFCARS Assessment Review. An AFCARS Assessment Review is conducted by the Children's Bureau. As with all AFCARS Assessment Reviews, Connecticut's review involved all members of the State and Federal teams of the Children's Bureau and the Office of Information Services as well as DCF strategic planning and regional staff. Connecticut's review occurred in July, 2001.

The purpose of the case file review is to verify that the electronic data submitted to AFCARS matches the data that is in the paper files. Because all adoption records are sealed, only foster care case files were included in Connecticut's AFCARS Assessment Review. (The Federal review team did not require Connecticut to unseal the adoption records due to time constraints in scheduling the review.)

The AFCARS reporting period reviewed by this team was for April 1, 2000 through September 30, 2000. The minimum tasks that were required to correct any deficiencies found in the AFCARS data are included in an AFCARS Improvement Plan. As occurred for Connecticut, test cases were provided once all of the required changes to the information system have been completed. The AFCARS Improvement Plan is considered to be completed once ACF and the State agree that the quality of the data is acceptable. No additional on-site reviews occur unless ACF hears of concerns about the quality of the State's data.

The AFCARS Assessment Review contains two major areas: 1) the AFCARS general requirements; and the 2) data elements. The AFCARS general requirements checks that the population ("population requirements") that is being reported to AFCARS and the technical requirements for constructing the data file ("technical requirements") are correct.

In the second major area of the AFCARS Assessment Review, there are 66 data elements related to foster care and 37 related to adoption that are examined. The data elements are checked to see whether they are within the guidelines of the AFCARS definitions for the information required, if the correct information is being entered and extracted, and the level of quality of the submitted data.

Each of the general information requirements and 103 data elements is given a compliance factor rating from 1 to 4, where 1=non-compliant and 4=fully compliant. Data elements or general requirements having programming logic problems receive factor ratings of "2" and those with data entry problems a factor rating of "3." Data elements and general requirements with a factor rating of 1, 2 or 3 are required to make corrections outlined by the reviewers, and a "compliant" rating (factor of 4) will only occur when all system and/or data quality issues have been corrected.

Table P-1 shows the AFCARS general requirements rating factors for population requirements and technical requirements for Connecticut and comparison States. In 2001, the Connecticut report cited significant deficiencies on both general requirements. While none of the comparison States were fully compliant at the time of their AFCARS

Assessment Review, there are also no comparison States to date that received such low scores in both requirement areas.

One of the concerns regarding the Connecticut population requirements, for example, is that Connecticut is not submitting the complete foster care population; the Department is incorrectly reporting children in trial home visits as having been discharged.

Concerns regarding the Connecticut technical requirements include improperly reporting case record numbers, missing historical information on removal episodes that occurred prior to 1993 when the earlier CMS automated system was in operation (prior to LINK).

Table P-1. AFCARS General Requirements Rating Factors

State	Population Requirements	Technical Requirements
Connecticut	2	1
Maine	2	2
Massachusetts	2	4
New Hampshire	4	2
New Jersey	Not yet reviewed	Not yet reviewed
New York	Not yet reviewed	Not yet reviewed
Rhode Island	2	3
Vermont	2	4

Source: U.S. Department of Health & Human Services Administration for Children & Families Children's Bureau AFCARS Assessment Review Findings-General Requirements (www.acf.hhs.gov/programs/cb/stats_research/afcars/aar/)

Table P-2 shows results for the second major area of the AFCARS Assessment Review, the quality of the adoption and foster care data elements. The table shows the percent of foster care and adoption data elements requiring system modifications (i.e. rated "1" or "2"). Connecticut has significantly more data elements requiring system modifications than the comparison States that have been reviewed to date.

One widespread error noted by the reviewers was that Connecticut defaulted missing data to a valid AFCARS code. For example, DCF policy requires an administrative case review (ACR) be conducted within 45 days of initial placement and every 6 months thereafter. At the time of the AFCARS Assessment Review, however,

LINK did not have the capability to collect and report the date of the most recent periodic review, and automatically entered when the review should have occurred as the actual review date.

This default of missing data to a valid AFCARS code led to misleading and inaccurate accounts of the children in foster care and children adopted as well as allowing the State to avoid financial penalties that might otherwise have applied.

Also found in the AFCARS Assessment Reviews were the absence of collection of case plan goals, runaway episodes and trial home visits. With respect to data entry, there was a lack of use of the system by case workers, and the reviewers recommended that additional training on the system and particular screens occur.

Table P-2. AFCARS Percent of Foster Care and Adoption Data Elements Requiring System Modifications

State	Foster Care Data Elements Requiring System Modifications	Adoption Data Elements Requiring System Modifications
Connecticut	83%	89%
Maine	36%	40%
Massachusetts	30%	40%
New Hampshire	41%	51%
New Jersey	Not yet reviewed	Not yet reviewed
New York	Not yet reviewed	Not yet reviewed
Rhode Island	30%	51%
Vermont	32%	22%

Source: U.S. Department of Health & Human Services Administration for Children & Families Children's Bureau AFCARS Assessment Review Findings-General Requirements (www.acf.hhs.gov/programs/cb/stats_research/afcars/aar/)

An AFCARS Improvement Plan was developed, containing the general requirements and data elements not in compliance with the Federal regulations. Written quarterly updates are submitted to the ACF Regional Office. Once the improvement plan has been completed, the State is given a set of test case scenarios, requiring entry and extraction of data, which is then compared to known answers for each test case scenario. Once the State and ACF concur that the data quality is acceptable, then the AFCARS Improvement Plan will be satisfied.